- Express one's knowledge and opinions to team members involved in client 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 client-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 client 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.[5]

General Barriers to Interprofessional Communication and Collaboration[6]

- Personal values and expectations
- Personality differences
- Organizational hierarchy
- Lack of cultural humility
- Generational differences
- Historical interprofessional and intraprofessional rivalries

5. O'Daniel, M., & Rosenstein, A. H. (2011). Professional communication and team collaboration. In: Hughes R.G. (Ed.). *Patient safety and quality: An evidence-based handbook for nurses.* Agency for Healthcare Research and Quality (US); Chapter 33. https://www.ncbi.nlm.nih.gov/books/NBK2637

6. O'Daniel, M., & Rosenstein, A. H. (2011). Professional communication and team collaboration. In: Hughes R.G. (Ed.). *Patient safety and quality: An evidence-based handbook for nurses.* Agency for Healthcare Research and Quality (US); Chapter 33. https://www.ncbi.nlm.nih.gov/books/NBK2637

- 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 client 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 7.5a.[7]

Table 7.5a. Initiatives to Overcome Barriers to Interprofessional Communication and Collaboration[8]

7. Weller, J., Boyd, M., & Cumin, D. (2014). Teams, tribes and patient safety: Overcoming barriers to effective teamwork in healthcare. *Postgraduate Medical Journal, 90*(1061), 149-154. https://doi.org/10.1136/postgradmedj-2012-131168

8. Weller, J., Boyd, M., & Cumin, D. (2014). Teams, tribes and patient safety: Overcoming barriers to effective teamwork in healthcare. *Postgraduate Medical Journal, 90*(1061), 149-154. https://doi.org/10.1136/postgradmedj-2012-131168

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 client 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 client 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 discussed in the following subsections.

ISBARR

A common format used by health care team members to exchange client information is **ISBARR**, a mnemonic for the components of **I**ntroduction,

Situation, **B**ackground, **A**ssessment, **R**equest/Recommendations, and **R**epeat back.[9,10]

- **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.
- **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.

9. Institute for Healthcare Improvement (n.d.). *ISBAR trip tick*. https://www.ihi.org/resources/tools/sbar-tool-situation-background-assessment-recommendation

10. Grbach, W., Vincent, L., & Struth, D. (2008). *Curriculum developer for simulation education*. QSEN Institute. https://qsen.org/reformulating-sbar-to-i-sbar-r/

Communication Guidelines for Nurses[11]

- 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 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

11. Studer Group. (2007). *Patient safety toolkit – Practical tactics that improve both patient safety and patient perceptions of care*. Studer Group. https://www.ncbi.nlm.nih.gov/books/NBK2637/table/ch33.t4/

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.”

View or print an ISBARR reference card.

Handoff Reports

Handoff reports are defined by The Joint Commission as “a transfer and acceptance of client care responsibility achieved through effective communication. It is a real-time process of passing client 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 client’s care.”[12] In 2017 The Joint Commission issued a sentinel alert about inadequate handoff communication that has resulted in client harm such as wrong-site surgeries, delays in treatment, falls, and medication errors.[13]

12. Starmer, A. J., Spector, N. D., Srivastava, R., Allen, A. D., Landrigan, C. P., Sectish, T. C., & I-Pass Study Group. (2012). I-PASS, a Mnemonic to Standardize Verbal Handoffs. *Pediatrics, 129*(2), 201-204. https://www.ipassinstitute.com/hubfs/I-PASS-mnemonic.pdf

13. The Joint Commission. (2017). *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[14]:

- Sender contact information
- Illness assessment, including severity
- Client 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.

Bedside Handoff Report Checklist

See Figure 7.2[15] for an example of a Bedside Handoff Report Checklist to improve nursing handoff reports by the Agency for Healthcare Research and

14. The Joint Commission. (2017). *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/

15. "Strat3_Tool_2_Nurse_Chklst_508.pdf" by AHRQ is licensed under CC0

Quality (AHRQ).[16] Although a bedside handoff report is similar to an ISBARR report, it contains additional information to ensure continuity of care across nursing shifts.

16. AHRQ. (n.d.). *Bedside shift report checklist*. https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/engagingfamilies/strategy3/Strat3_Tool_2_Nurse_Chklst_508.pdf

Bedside Shift Report Checklist

- ☐ Introduce the nursing staff to the patient and family. Invite the patient and family to take part in the bedside shift report.
- ☐ Open the medical record or access the electronic work station in the patient's room.
- ☐ Conduct a verbal SBAR report with the patient and family. Use words that the patient and family can understand.
  - **S** = **Situation**. What is going on with the patient? What are the current vital signs?
  - **B** = **Background**. What is the pertinent patient history?
  - **A** = **Assessment**. What is the patient's problem now?
  - **R** = **Recommendation**. What does the patient need?
- ☐ Conduct a focused assessment of the patient and a safety assessment of the room.
  - Visually inspect all wounds, incisions, drains, IV sites, IV tubings, catheters, etc.
  - Visually sweep the room for any physical safety concerns.
- ☐ Review tasks that need to be done, such as:
  - Labs or tests needed
  - Medications administered
  - Forms that need to be completed (e.g., admission, patient intake, vaccination, allergy review, etc.)
  - Other tasks: _____
- ☐ Identify the patient's and family's needs or concerns.
  - Ask the patient and family:
    - *"What could have gone better during the last 12 hours?"*
    - *"Tell us how your pain is."*
    - *"Tell us how much you walked today."*
    - *"Do you have any concerns about safety?"*
    - *"Do you have any worries you would like to share?"*
  - Ask the patient and family what the goal is for the next shift. This is the patient's goal — not the nursing staff's goal for the patient.
    - *"What do you want to happen during the next 12 hours?"*
    - Follow up to see if the goal was met during the verbal SBAR at the next bedside shift report.

Adapted from the Emory University Bedside Shift Report Bundle.

AHRQ Agency for Healthcare Research and Quality
Advancing Excellence in Health Care • www.ahrq.gov

Guide to Patient and Family Engagement

Figure 7.2 Bedside Handoff Report Checklist

Print a copy of the AHRQ Bedside Shift Report Checklist.[17]

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. See Figure 7.3[18] for an illustration of closed-loop communication.

17. AHRQ. (n.d.). *Bedside shift report checklist*. https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/engagingfamilies/strategy3/Strat3_Tool_2_Nurse_Chklst_508.pdf

18. Image is derivative of "close-loop.png" by unknown and is licensed under CC0. Access for free at https://www.ahrq.gov/teamstepps/instructor/essentials/pocketguide.html

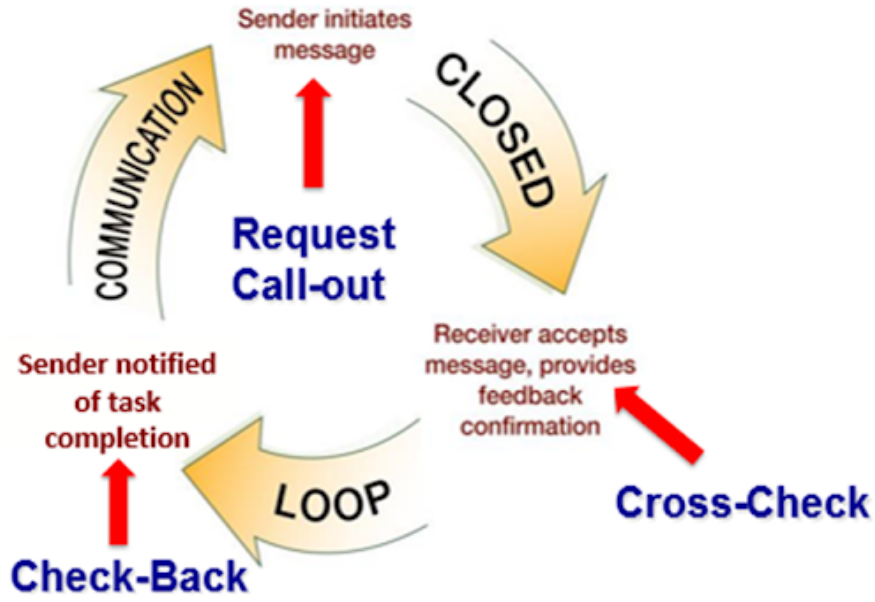


Figure 7.3 Closed-Loop Communication

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[19]:

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.[20]

Table 7.5b. Sample I-PASS Verbal Handoff[21]

19. The Joint Commission. (2017). *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/

20. Starmer, A. J., Spector, N. D., Srivastava, R., Allen, A. D., Landrigan, C. P., Sectish, T. C., & I-Pass Study Group. (2012). I-PASS, a Mnemonic to Standardize Verbal Handoffs. *Pediatrics, 129*(2), 201-204. https://www.ipassinstitute.com/hubfs/I-PASS-mnemonic.pdf

21. Starmer, A. J., Spector, N. D., Srivastava, R., Allen, A. D., Landrigan, C. P., Sectish, T. C., & I-Pass Study Group. (2012). I-PASS, a Mnemonic to Standardize Verbal Handoffs. *Pediatrics, 129*(2), 201-204. https://www.ipassinstitute.com/hubfs/I-PASS-mnemonic.pdf

I	**Illness Severity**	This is our sickest client 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.

Listening Skills

Effective team communication includes both the delivery and receipt of the message. Listening skills are a fundamental element of the communication loop. For nursing staff, this involves listening to clients, families, and coworkers. Active listening involves not just hearing the individual words that someone states, but also understanding the emotions and concerns behind the words. Employing active listening reflects an empathetic approach and can improve client outcomes and foster teamwork.

Nurses often serve as the communication bridge between clients, families, and other health care team members. By listening attentively to colleagues, nurses can ensure that important information is accurately conveyed, reducing the risk of misunderstandings and enhancing the overall efficiency of care delivery. This collaborative environment fosters a culture of mutual respect and support, ultimately leading to better health care outcomes.

In order to develop active listening skills, individuals should practice mindfulness and practice their communication techniques. Listening skills

can be cultivated with eye contact, actions such as nodding, and demonstration of other nonverbal strategies to demonstrate engagement. Maintaining an open posture, smiling, and attentiveness are all nonverbal strategies that can facilitate communication. It is important to take measures to avoid distractions, offer a summation of the communication, and ask clarifying questions to further develop the communication.

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. Please see a list of error prone abbreviations in the box below.

- 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 client safety. Please see Figure 7.4[22] for an image of a nurse accessing a client's EHR.

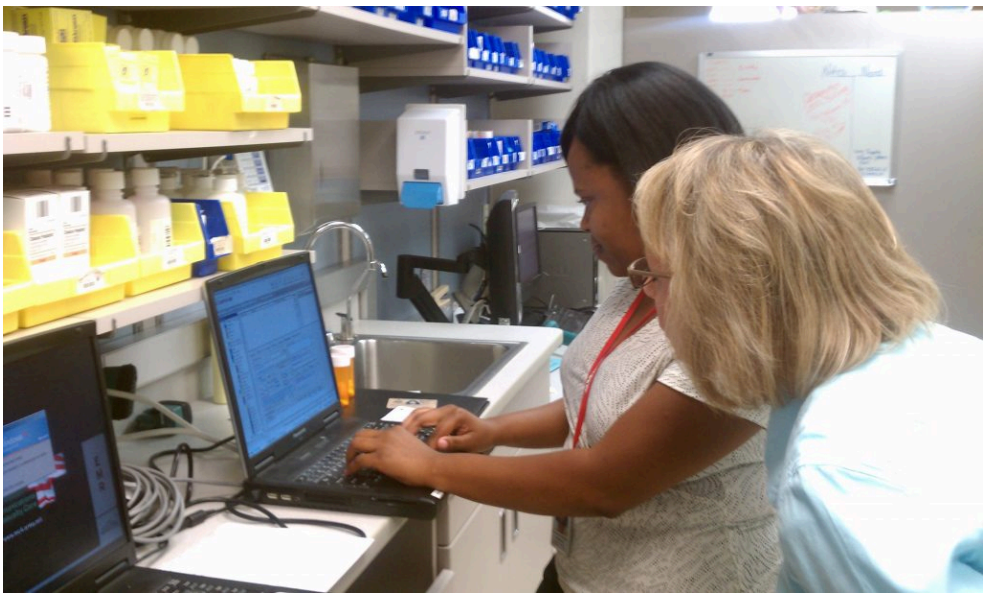


Figure 7.4 Documenting in the EHR

Electronic Health Record

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

22. "Winn_Army_Community_Hospital_Pharmacy_Stays_Online_During_Power_Outage.jpg" by Flickr user MC4 Army is licensed under CC BY 2.0

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. Read more about nursing care plans in the "Planning" section of the "Nursing Process" chapter in Open RN *Nursing Fundamentals, 2e*.

7.6 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 using structured interprofessional communication strategies, 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 client/population-centered care and population health programs and policies that are safe, timely, efficient, effective, and equitable."[1] See the following box for the components of this IPEC competency.

Components of IPEC's Teams and Teamwork Competency[2]

- 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 client-centered and population-focused problem-solving.
- Integrate the knowledge and experience of health and other professions to inform health and care decisions, while respecting client and community values and priorities/

1. Interprofessional Education Collaborative. (2023). *IPEC core competencies*. https://www.ipecollaborative.org/ipec-core-competencies

2. Interprofessional Education Collaborative. (2023). *IPEC core competencies*. https://www.ipecollaborative.org/ipec-core-competencies

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 clients, families, and community members.
- Share accountability with other professions, clients, 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 client-

centered, safe, timely, effective, efficient, and equitable.[3] See Figure 7.5[4] for an image illustrating interprofessional teamwork.



Figure 7.5 Interprofessional Teamwork

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 client conditions. Qualities of a successful team are described in the following box.[5]

3. 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

4. "400845937-huge.jpg" by Flamingo Images is used under license from Shutterstock.com

5. O'Daniel, M., & Rosenstein, A. H. (2011). Professional communication and team collaboration. In: Hughes R.G. (Ed.). *Patient safety and quality: An evidence-based handbook for nurses.* Agency for Healthcare Research and Quality (US); Chapter 33. https://www.ncbi.nlm.nih.gov/books/NBK2637

Qualities of A Successful Team[6]

- 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

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

6. O'Daniel, M., & Rosenstein, A. H. (2011). Professional communication and team collaboration. In: Hughes R.G. (Ed.). *Patient safety and quality: An evidence-based handbook for nurses.* Agency for Healthcare Research and Quality (US); Chapter 33. https://www.ncbi.nlm.nih.gov/books/NBK2637

initiative to improve client safety by improving teamwork skills and communication.[7]

View this video about the TeamSTEPPS® framework[8]:

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://wtcs.pressbooks.pub/nursingmpc/?p=1032#oembed-1

TeamSTEPPS® is based on establishing team structure and four teamwork skills: communication, leadership, situation monitoring, and mutual support.[9] See Figure 7.6[10] for an image of the TeamSTEPPS® framework followed by a description of each TeamSTEPPS® skill. The components of this model are described in the following subsections.

7. AHRQ. (2024). *TeamSTEPPS 3.0.* https://www.ahrq.gov/teamstepps/instructor/index.html

8. AHRQ Patient Safety. (2015, April 29). *TeamSTEPPS overview* [Video]. YouTube. All rights reserved. https://youtu.be/p4n9xPRtSuU

9. AHRQ. (2024). *TeamSTEPPS: 3.0 Pocket guide*. https://www.ahrq.gov/teamstepps-program/resources/pocket-guide/index.html

10. "tslogo1med.jpg" by unknown author is licensed under Public Domain. Access for free at https://www.ahrq.gov/teamstepps/instructor/essentials/pocketguide.html



Figure 7.6 TeamSTEPPS® Framework

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.

These communication strategies are further described in the "Interprofessional Communication" section of this chapter.

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[11]:

- 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 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

11. AHRQ. (2024). *TeamSTEPPS: 3.0 Pocket guide*. https://www.ahrq.gov/teamstepps-program/resources/pocket-guide/index.html.

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®.[12]

Brief Checklist

During the brief, the team should address the following questions[13]:

___ 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?

12. AHRQ. (2024). *TeamSTEPPS: 3.0 Pocket guide*. https://www.ahrq.gov/teamstepps-program/resources/pocket-guide/index.html

13. AHRQ. (2024). *TeamSTEPPS: 3.0 Pocket guide*. https://www.ahrq.gov/teamstepps-program/resources/pocket-guide/index.html

___ 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 client 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 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.[14] See the following box for a Debrief Checklist.

14. AHRQ. (2024). *TeamSTEPPS: 3.0 Pocket guide*. https://www.ahrq.gov/teamstepps-program/resources/pocket-guide/index.html

Debrief Checklist[15]

The team should address the following questions during a debrief:

___ Was communication clear?

___ Were roles and responsibilities understood?

___ 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 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

15. AHRQ. (2024). *TeamSTEPPS: 3.0 Pocket guide*. https://www.ahrq.gov/teamstepps-program/resources/pocket-guide/index.html

awareness and know what is going on as situations evolve. The STEP tool is used by team leaders to assist with situation monitoring.[16]

STEP

The **STEP tool** is a situation monitoring tool used to know what is going on with you, your clients, your team, and your environment. **STEP** stands for **S**tatus of the clients, **T**eam members, **E**nvironment, and **P**rogress toward goal. See an illustration of STEP in Figure 7.7.[17] The components of the STEP tool are described in the following box.[18]

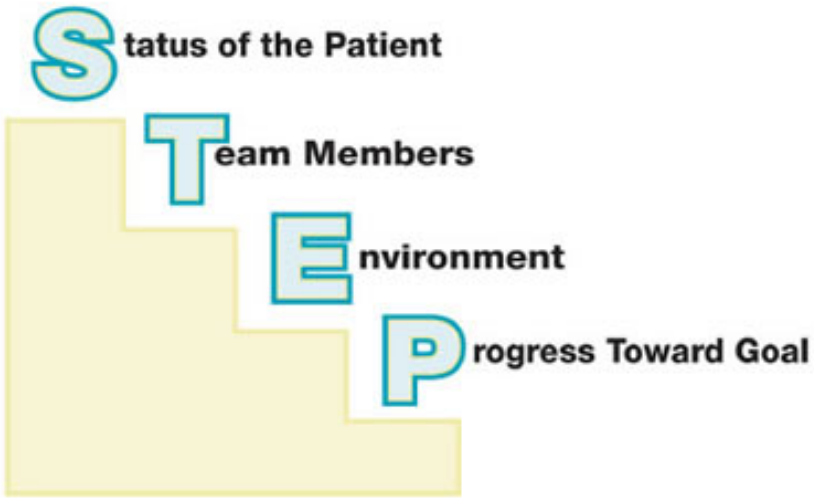


Figure 7.7 STEP Tool

16. AHRQ. (2024). *TeamSTEPPS: 3.0 Pocket guide*. https://www.ahrq.gov/teamstepps-program/resources/pocket-guide/index.html

17. "stepfig1.jpg" by unknown author is licensed under Public Domain. Access for free at https://www.ahrq.gov/teamstepps/instructor/essentials/pocketguide.html

18. AHRQ. (2024). *TeamSTEPPS: 3.0 Pocket guide*. https://www.ahrq.gov/teamstepps-program/resources/pocket-guide/index.html

STEP Tool[19]

Status of Clients: "What is going on with your clients?"

__ 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

19. AHRQ. (2024). *TeamSTEPPS: 3.0 Pocket guide*. https://www.ahrq.gov/teamstepps-program/resources/pocket-guide/index.html

__ Equipment

Progression Towards Goal:

__ Status of the Team's Clients

__ Established Goals of the Team

__ Tasks/Actions of the Team

__ Appropriateness of the Plan and 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[20]:

- 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 client care. See the I'M SAFE Checklist in the following box.[21] 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

20. AHRQ. (2024). *TeamSTEPPS: 3.0 Pocket guide*. https://www.ahrq.gov/teamstepps-program/resources/pocket-guide/index.html

21. AHRQ. (2024). *TeamSTEPPS: 3.0 Pocket guide*. https://www.ahrq.gov/teamstepps-program/resources/pocket-guide/index.html

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.[22]

I'm SAFE Checklist[23]

__ **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 client codes and another develops a postoperative hemorrhage. The charge nurse is performing situation monitoring by continually scanning and

22. AHRQ. (2024). *TeamSTEPPS: 3.0 Pocket guide*. https://www.ahrq.gov/teamstepps-program/resources/pocket-guide/index.html

23. AHRQ. (2024). *TeamSTEPPS: 3.0 Pocket guide*. https://www.ahrq.gov/teamstepps-program/resources/pocket-guide/index.html

assessing the status of all clients 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 clients they have been assigned. The charge nurse creates a shared mental model by ensuring all team members are aware of their evolving responsibilities as the situation changes. The charge nurse directs additional assistance to the emergent clients while also ensuring appropriate coverage for the other clients on the unit to ensure all clients receive safe and effective care.

For example, as the "code" is called, the charge nurse directs two additional nurses and two additional assistive personnel to assist with the emergent clients while the other nurses and unlicensed assistive personnel are directed to "cover" the remaining clients, answer call lights, and assist clients to the bathroom to prevent falls. Additionally, the charge nurse is aware that after performing a few rounds of CPR for the coding client, the unlicensed assistive personnel must be switched with another team member to maintain effective chest compressions. As the situation progresses, the charge nurse evaluates the status of all clients 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." Mutual support includes providing task assistance, giving feedback, and advocating for client 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[24]:

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

Example of Task Assistance

In a previous example, one client on the unit was coding while another was experiencing a postoperative hemorrhage. After the emergent care was provided and the hemorrhaging client was stabilized, Sue, the nurse caring for the hemorrhaging client, finds many scheduled medications for her other clients 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 client so Sue can administer oral medications to her remaining clients. 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 client safety.

24. AHRQ. (2024). *TeamSTEPPS: 3.0 Pocket guide*. https://www.ahrq.gov/teamstepps-program/resources/pocket-guide/index.html

FEEDBACK

Feedback is provided to a team member for the purpose of improving team performance. Effective feedback should follow these parameters[25]:

- *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.

ADVOCATING FOR SAFETY WITH ASSERTIVE STATEMENTS

When a team member perceives a potential client safety concern, they should assertively communicate with the decision-maker to protect client 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[26]:

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

25. AHRQ. (2024). *TeamSTEPPS: 3.0 Pocket guide*. https://www.ahrq.gov/teamstepps-program/resources/pocket-guide/index.html

26. AHRQ. (2024). *TeamSTEPPS: 3.0 Pocket guide*. https://www.ahrq.gov/teamstepps-program/resources/pocket-guide/index.html

Examples of Using Assertive Statements to Promote Client Safety

A nurse notices that a team member did not properly wash their hands during client care. Feedback is provided immediately in a private area after the team member left the client room: *"I noticed you didn't wash your hands when you entered the client's room. Can you help me understand why that didn't occur?" (Wait for an answer.) "Performing hand hygiene is essential for protecting our clients 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.[27]

27. AHRQ. (2024). *TeamSTEPPS: 3.0 Pocket guide*. https://www.ahrq.gov/teamstepps-program/resources/pocket-guide/index.html

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!"[28] See Figure 7.8[29] for an illustration of CUS assertive statements.



Figure 7.8 CUS Assertive Statements

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

28. AHRQ. (2024). *TeamSTEPPS: 3.0 Pocket guide*. https://www.ahrq.gov/teamstepps-program/resources/pocket-guide/index.html

29. "cusfig1.jpg" by unknown author is licensed under Public Domain. Access for free at https://www.ahrq.gov/teamstepps/instructor/essentials/pocketguide.html

safety and emphasize the importance of these initiatives to promote client safety.

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

Assertive Statement Example

A nurse observes a new physician resident preparing to insert a central line at a client'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."

MANAGING CONFLICT

Conflict is not uncommon on interprofessional teams, especially when there are diverse perspectives from multiple staff regarding client 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[30]:

- **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.

Example of Using the DESC Tool[31]

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

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

E: "I'm concerned how you addressed that issue in front of the

30. AHRQ. (2024). *TeamSTEPPS: 3.0 Pocket guide*. https://www.ahrq.gov/teamstepps-program/resources/pocket-guide/index.html

31. AHRQ. (2024). *TeamSTEPPS: 3.0 Pocket guide*. https://www.ahrq.gov/teamstepps-program/resources/pocket-guide/index.html

client and three other staff members. It made me feel bad in front of the client 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."

Managing interpersonal conflict resolution is described further in the "Conflict Resolution" section.

View a supplementary detailed video webinar from AHRQ describing the TeamSTEPPS® principles at youtu.be/fxlRtpzsUug.[32]

Team Qualitities Case Application (*Answers can be found at the end of book)*

Mary is recovering from a stroke and requires comprehensive care involving multiple disciplines. Her care team has scheduled interdisciplinary team meetings twice a week to discussion

32. 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

Mary's progress, adjust her care plan, and address any concerns. Dr. Patel is Mary's primary physician and consults with Chris (physical therapist) and Emily (speech therapist) before making any changes to Mary's medication that might affect her therapy sessions. Chris and Emily coordinate their therapy schedules to help maximize Mary's participation and avoid conflicting sessions and fatigue. Laura is Mary's social worker and has a large roster of clients. Laura struggles to include Mary's family in the discharge planning discussions but feels that she has identified an appropriate facility that Mary and her family will be receptive to for discharge. She moves forward with the client placement paperwork. Lisa is Mary's dietician, and she has identified a dietary plan that will best contribute to Mary's nutritional needs and healing. She acknowledges that Mary's dietary preferences are much different than what she has selected in her dietary plan, but Lisa knows that she has identified the best dietary plan to meet Mary's energy needs.

Identify which team members are demonstrating team success strategies and how they are demonstrated?

Which team members are not demonstrating team success strategies? How could these team members modify their approach?

7.7 Conflict Resolution

Conflicts are inevitable when working on a team composed of members with different personalities, roles, and responsibilities. It is essential for all nurses to develop conflict resolution skills.

Common Sources of Interpersonal Conflict

Common sources of interpersonal conflict in health care settings are passive-aggressiveness, horizontal aggression, defensiveness, peer informer behavior, and victimization behaviors.[1]

Passive-Aggressiveness

Passive-aggressiveness is a behavior that shows disconnection between what a person says and does. Many times, a passive-aggressive person will agree with another person's request, but later express feelings of frustration or anger to others and not comply with the request.

As an example, a charge nurse informs the team of RNs in a team meeting that a new policy requires bedside rounding. A nurse responds enthusiastically during the meeting but then complains to others about the policy and refuses to do it. The best method of managing passive-aggressive behavior is to confront it calmly and directly. For this example, it would be helpful for the charge nurse to say, *"I was disappointed to hear you are upset about the new bedside rounding policy because you didn't express any*

1. Elizabeth, A. (2019). Managing interpersonal conflict: Steps for success. *Nursing Management, 50*(6), 22-28. https://journals.lww.com/nursingmanagement/Fulltext/2019/06000/Managing_interpersonal_conflict__Steps_for_success.7.aspx

concerns directly to me. It would be helpful for you to directly communicate concerns to me so we can discuss them and make a plan for going forward."[2]

Horizontal Aggression

The nursing literature describes diffuse incivility, lateral/horizontal violence, and bullying among nurses in the workplace.[3] **Horizontal aggression** refers to hostile behavior among one's peers. It is not acceptable and should be directly confronted in a constructive manner or it will get worse. A suggested approach to a peer displaying horizontal aggression is to respond calmly and sincerely, *"I value your expertise and experience and am looking for your help and support."* If the negative behavior continues after an attempt to address the individual directly, the nurse supervisor should be notified according to the agency's chain of command.[4]

Defensiveness

It can be difficult to receive negative feedback. Some people respond by

2. Elizabeth, A. (2019). Managing interpersonal conflict: Steps for success. *Nursing Management, 50*(6), 22-28. https://journals.lww.com/nursingmanagement/Fulltext/2019/06000/Managing_interpersonal_conflict__Steps_for_success.7.aspx

3. Bambi, S., Guazzini, A., De Felippis, C., Lucchini, A., & Rasero, L. (2017). Preventing workplace incivility, lateral violence and bullying between nurses. A narrative literature review. *Acta bio-medica: Atenei Parmensis, 88*(5S), 39–47. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6357576/

4. Elizabeth, A. (2019). Managing interpersonal conflict: Steps for success. *Nursing Management, 50*(6), 22-28. https://journals.lww.com/nursingmanagement/Fulltext/2019/06000/Managing_interpersonal_conflict__Steps_for_success.7.aspx

becoming defensive. Defensiveness puts the blame for one's shortcomings on another person to make oneself appear better.

As an example, a charge nurse addresses a nurse about not turning on the bed alarm after repositioning a client and leaving the room. The nurse responds defensively by inaccurately blaming others, stating, *"The nursing assistants are always sloppy with their responsibilities."* It is helpful to confront defensiveness by restating the facts in a calm manner and redirecting the conversation to the problem, its resolution, and the risk of jeopardizing client safety. For example, the charge nurse could reply, *"In this situation, I saw you leave the room after repositioning the client, and when I went into the room to answer the client's call light, the bed alarm was off."*[5]

Peer Informer Behavior

Peer informer behavior is similar to gossip. Peer informers relay information about fellow team members to the nurse leader, and this information often lacks objective evidence. It is often best to respond to the informer by asking them to speak to their team member directly about their concerns unless it is an urgent matter that must be dealt with immediately. However, keep in mind that if concerns are shared about a staff member by more than one team member, it may be a pattern of behavior, and the nurse leader should follow up with that staff member.[6]

5. Elizabeth, A. (2019). Managing interpersonal conflict: Steps for success. *Nursing Management,* 50(6), 22-28. https://journals.lww.com/nursingmanagement/Fulltext/2019/06000/Managing_interpersonal_conflict__Steps_for_success.7.aspx
6. Elizabeth, A. (2019). Managing interpersonal conflict: Steps for success. *Nursing Management, 50*(6), 22-28. https://journals.lww.com/nursingmanagement/Fulltext/2019/06000/Managing_interpersonal_conflict__Steps_for_success.7.aspx

As an example, a nurse approaches the charge nurse and says, *"Everyone is concerned about how much time Nancy is spending in the room with her clients. She gets behind in her work and the rest of us have to make up for it."* The charge nurse could reply, *"Have you addressed your concerns directly with Nancy?"* If the nurse replies, *"No,"* then the charge nurse could state, *"Please talk to Nancy directly with your concerns first."* However, if another nurse shares a similar concern with the charge nurse, then the charge nurse should address this pattern of behavior with Nancy and obtain her perspective.

Victimization

Victimization occurs when a team member feels they are being singled out unfairly or held to higher expectations than their peers. Comments may include, "Why am I getting called out on this when other people are doing this and aren't getting in trouble?" or "I was never told this; why am I always the last to know?" Team members who feel victimized should be reminded by the nurse leader they are held to the same standards as the other members. However, keep in mind that sharing information about other staff members' performance breaches confidentiality, so do not include another employees' performance information in conversations but instead focus on policies and procedures that apply to everyone.[7]

Types of Conflict

There are various sources of conflict that nurses may encounter in their work environment.

Role Conflict: Role conflict arises when individuals have multiple, often

7. Elizabeth, A. (2019). Managing interpersonal conflict: Steps for success. *Nursing Management, 50*(6), 22-28. https://journals.lww.com/nursingmanagement/Fulltext/2019/06000/Managing_interpersonal_conflict__Steps_for_success.7.aspx

conflicting, expectations associated with their roles. In professional settings, an employee may face role conflict when their job responsibilities are unclear or when there are conflicting demands from different supervisors. For example, a project manager might experience tension if their role requires them to enforce strict deadlines while also being expected to accommodate frequent changes in project scope. This type of conflict can lead to stress, decreased job satisfaction, and reduced productivity. Role conflict can be mitigated by clear communication, well-defined job descriptions, and regular feedback to ensure alignment of expectations.[8]

Communication Conflict: Communication conflict occurs when there is a failure in the exchange of information. Misunderstandings, misinterpretations, and lack of effective communication can lead to disputes and frustrations. For instance, in a team setting, if one member interprets a directive differently from others, it can result in duplicated efforts or missed tasks. Communication conflict is often exacerbated by differences in communication styles, cultural backgrounds, or language barriers. Addressing this type of conflict involves fostering an environment of open and clear communication, utilizing active listening techniques, and ensuring that all parties have a mutual understanding of the messages being conveyed.[9]

Goal Conflict: Goal conflict happens when the objectives of individuals or groups are incompatible. In organizations, different departments might

8. Ahmad, M., & Ud din, S. (2023). Effect of role conflict and role ambiguity on employee creativity. *Library Philosophy and Practice (ejournal), 7615*, 1-21. https://digitalcommons.unl.edu/cgi/viewcontent.cgi?article=14720&context=libphilprac

9. Hutagaung, I. (2017). The function of interpersonal communication in conflict management organization. *SHS Web of Conferences, 33*. https://www.researchgate.net/publication/313290661_The_Function_of_Interpersonal_Communication_in_Conflict_Management_Organization

pursue goals that are in opposition, such as a sales team aiming for maximum customer satisfaction while a production team focuses on minimizing costs. These conflicting goals can hinder overall progress and lead to tension among team members. To resolve goal conflicts, it is crucial to align individual and departmental goals with the broader objectives of the organization. This can be achieved through strategic planning, cross-functional collaboration, and regular goal-setting meetings that ensure all efforts are directed towards a common purpose.[10]

Personality Conflict: Personality conflict arises from differences in individual temperaments, attitudes, and behaviors. Such conflicts are common in any setting where diverse personalities interact, such as workplaces, schools, or social groups. For example, a highly extroverted person might clash with a reserved colleague, leading to friction in their interactions. Personality conflicts can negatively impact team cohesion and productivity. Managing these conflicts involves fostering a culture of respect and understanding, providing training in emotional intelligence and conflict resolution, and encouraging individuals to appreciate and leverage the strengths of diverse personalities.[11]

Ethical/Values Conflict: Ethical or values conflict occurs when individuals or groups have fundamentally different beliefs and values. These conflicts are often deeply rooted and can be particularly challenging to resolve. In a corporate environment, an ethical conflict might arise if one employee believes in strict adherence to company policies while another prioritizes flexibility and personal judgment. Values conflicts can also occur over issues

10. Gray, J. S., Ozer, D. J., & Rosenthal, R. (2017). Goal conflict and psychological well-being: A meta-analysis. *Journal of Research in Personality, 66*, 27-37. https://doi.org/10.1016/j.jrp.2016.12.003

11. Tehrani, H. D., & Yamini, S. (2020). Personality traits and conflict resolution styles: A meta-analysis. *Personality and Individual Differences, 157*. https://doi.org/10.1016/j.paid.2019.109794

such as diversity, environmental responsibility, and corporate social responsibility. Addressing ethical or values conflicts requires creating an environment of mutual respect, where different perspectives are valued. Organizations can benefit from having clear ethical guidelines and fostering an inclusive culture that encourages open dialogue and ethical decision-making.[12]

Conflict Management

Individuals manage conflict differently. During conflict, a person's behavior is typically driven by their commitment to their goals or their commitment to relationships[13]:

- **Commitment to goals:** The extent to which an individual attempts to satisfy their personal concerns or goals.
- **Commitment to relationships:** The extent to which an individual attempts to satisfy the concerns of another party or maintain the relationship with the other party.

Most people use different methods to resolve conflict depending on the situation and what strategy best applies. One approach is not necessarily better than another, and all approaches can be learned and used effectively with practice. However, to effectively manage conflict, it is important to first analyze the situation and then respond accordingly.

A long-standing conflict resolution model created by Thomas and Killmann

12. Xing, S. (2022). Ethical conflict and knowledge hiding in teams: Moderating role of workplace friendship in education sector. *Front Psychology, 13*. https;//doi.org/10.3389/fpsyg.2022.824485.

13. Wagner, J. (2018). *Leadership and Influencing Change in Nursing*. University of Regina Press. https://pressbooks.pub/leadershipandinfluencingchangeinnursing/

describes five approaches to dealing with conflict: avoiding, competing, accommodating, compromising, and collaborating. Each of these steps is further described in the following subsections.[14]

Avoidance Approach

An avoidance approach to conflict resolution 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. See Table 7.7a for types of avoidance, potential results, and situations when this strategy may be appropriate.[15]

Table 7.7a. Avoidance Approach[16]

14. Wagner, J. (2018). *Leadership and Influencing Change in Nursing*. University of Regina Press. https://pressbooks.pub/leadershipandinfluencingchangeinnursing/

15. Wagner, J. (2018). *Leadership and Influencing Change in Nursing*. University of Regina Press. https://pressbooks.pub/leadershipandinfluencingchangeinnursing/

16. Wagner, J. (2018). *Leadership and Influencing Change in Nursing*. University of Regina Press. https://pressbooks.pub/leadershipandinfluencingchangeinnursing/

Types of Avoidance Approaches	Potential Results	Appropriate Use
• Leaving the area • Withdrawing mentally • Changing the subject • Blaming or minimizing • Denying the problem exists • Postponing resolution to a later time (that may never occur) • Displaying emotions (tears, anger, etc.)	• The dispute is not resolved. • Disputes often build up and may eventually explode. • Low team member satisfaction may result from lack of conflict management. • Stress spreads to other parties (e.g., coworkers, family).	• The issue is trivial or unimportant. • Another issue is more urgent. • The potential disadvantages outweigh the potential benefits. • The timing for dealing with the conflict is currently inappropriate (due to overwhelming emotions or lack of information).

Application to Nursing

In a clinical setting, there may be times when it is appropriate to avoid confrontation. For example, on a particularly busy day in the emergency department, a client in a life-threatening condition was recently received. The attending physician shouts orders to the nurse in a disrespectful manner. The nurse avoids addressing the conflict until after the client has been stabilized and then shares their concerns. However, if the physician continues to bark orders to nursing staff in nonemergency situations, avoidance is no longer

appropriate, and the conflict must be addressed to establish a positive and respectful working environment.[17]

Competitive Approach

A competitive approach to conflict management demonstrates a high commitment to goals and a low commitment to relationships. Individuals who use the competitive approach pursue their goals at other individuals' expense and will use whatever power is necessary to win. A competitive approach may be displayed when an individual defends an action, belief, interest, or value they believe to be correct. Competitive approaches may also be supported by infrastructure (agency promotion procedures, courts of law, legislature, etc.).[18] See Table 7.7b for types of competitive approaches, potential results, and appropriate uses.

Table 7.7b. Competitive Approach[19]

17. Wagner, J. (2018). *Leadership and Influencing Change in Nursing*. University of Regina Press. https://pressbooks.pub/leadershipandinfluencingchangeinnursing/

18. Wagner, J. (2018). *Leadership and Influencing Change in Nursing*. University of Regina Press. https://pressbooks.pub/leadershipandinfluencingchangeinnursing/

19. Wagner, J. (2018). *Leadership and Influencing Change in Nursing*. University of Regina Press. https://pressbooks.pub/leadershipandinfluencingchangeinnursing/

Types of Competitive Approaches	Potential Results	Appropriate Use
• Using power of authority, position, or majority • Using power of persuasion • Using high-pressure techniques (e.g., threats, force, intimidation) • Disguising the issue • Tying relationship to conflict	• The conflict may escalate or the other party may withdraw. • The quality and durability of agreement may be reduced. • It is assumed the other party will not reciprocate. However, when feeling threatened, people tend to reach for whatever power they have. • The likelihood of future problems between conflicting parties is increased. • Communication and trust decrease.	• Short and quick action is vital. • The competitive strategy may be helpful for certain management decisions (e.g., enforcing unpopular rules, cutting costs, enforcing disciplinary measures).

Application to Nursing

A competitive approach to conflict resolution may be appropriate in a clinical setting if a nurse leader realizes a nurse has made an error while preparing to administer IV medication to a client. The nurse leader may stop the nurse from inaccurately administering the medication and take over completing the procedure. In this case, the goal of client safety outweighs the commitment to the relationship with that nurse. However, after client safety is maintained, it would be inappropriate to continue the competitive approach when debriefing the nurse about a simple human error. Debriefing should focus on educating the nurse about policy and procedures to improve their performance. However, if it is determined the nurse was acting recklessly and disciplinary measures must be instituted by a manager, then

the competitive approach may be appropriate.[20] This approach to responding to errors is often referred to as "Just Culture." Read more about Just Culture in the "Legal Implications" chapter.

Accommodating Approach

An accommodating approach to conflict management demonstrates a low commitment to goals and high commitment to relationships. This approach is the opposite of the competitive approach. It occurs when a person ignores or overrides their own concerns to satisfy the concerns of the other party. An accommodating approach is often used to establish reciprocal adaptations or adjustments, but when the other party does not reciprocate, conflict can result. Accommodators typically do not ask for anything in return but can become resentful when a reciprocal relationship isn't established. If resentment grows, individuals relying on the accommodating approach may shift to a competitive approach from a feeling of "being used" that can lead to conflict.[21] See Table 7.7c for types of the accommodating approach, potential results, and appropriate uses.

Table 7.7c. Accommodating Approach[22]

20. Wagner, J. (2018). *Leadership and Influencing Change in Nursing*. University of Regina Press. https://pressbooks.pub/leadershipandinfluencingchangeinnursing/

21. Wagner, J. (2018). *Leadership and Influencing Change in Nursing*. University of Regina Press. https://pressbooks.pub/leadershipandinfluencingchangeinnursing/

22. Wagner, J. (2018). *Leadership and Influencing Change in Nursing*. University of Regina Press. https://pressbooks.pub/leadershipandinfluencingchangeinnursing/

Types of Accommodating Approaches	Potential Results	Appropriate Use
• Playing down the conflict to maintain surface harmony • Self-sacrificing • Yielding to the other point of view	• The accommodating approach builds relationships that encourage more effective future problem-solving. • Accommodation increases the chances that the other party may be more accommodating to your needs in the future. • Communication is not improved.	• The outcome or issue is more important to the other party. • Preserving harmony is more important than the outcome. • It is necessary to build good faith for future problem-solving. • Your position could be damaged by a competitive approach. • Your previous action was incorrect.

Application to Nursing

It may be appropriate to use an accommodating approach when one of the nurses on your team has a challenging client who is taking up a lot of time and effort. By being situationally aware and noticing the nurse has been involved in that client's room for a long period of time, you offer to provide task assistance in an effort to provide mutual support. You are aware this will increase your workload for a short period of time, but it will assist your colleague and promote a strong team. However, the accommodating

approach is no longer appropriate if the nurse continues to expect you to cover their tasks after the situation has been resolved.[23]

Compromising Approach

A compromising approach to conflict resolution strikes a balance between commitment to goals and commitment to relationships. The objective of a compromising approach is a quick solution that will work for both parties. It typically involves both parties giving up something in return for something, thereby "meeting in the middle."[24] See Table 7.7d for types of compromising approaches, potential results, and appropriate uses.

Table 7.7d. Compromising Approach

23. Wagner, J. (2018). *Leadership and Influencing Change in Nursing*. University of Regina Press. https://pressbooks.pub/leadershipandinfluencingchangeinnursing/

24. Wagner, J. (2018). *Leadership and Influencing Change in Nursing*. University of Regina Press. https://pressbooks.pub/leadershipandinfluencingchangeinnursing/

Types of Compromising Approaches	Potential Results	Appropriate Use
• Splitting the difference • Exchanging concessions • Finding middle ground	• Both parties may feel they lost the battle and want to “get even” next time. • A relationship between the two parties is not established, although it does not cause the deterioration of relationships. • There is a danger of stalemate if one or both parties refuse to “give up” anything. • Compromising does not explore the issue in depth.	• Compromising works well when quick solutions are required due to time pressures. • Compromising may be appropriate when collaboration or competition fails. • Short-term solutions are needed until more information can be obtained.

Application to Nursing

Compromise is an appropriate approach to conflict in many clinical settings. For example, you are working with another nurse who rarely assists other team members. The nurse asks you for assistance with a blood draw for a client. You hesitate because you are searching for a lunch tray that has not yet been delivered for a client with diabetes. You ask your colleague to obtain the client’s lunch tray while you complete their request for assistance with a blood draw. It would be inappropriate to refuse to assist the nurse based on their reputation because this could impact safe, effective care for the client.[25]

Collaborative Approach

The collaborative approach to conflict resolution demonstrates a high

25. Wagner, J. (2018). *Leadership and Influencing Change in Nursing*. University of Regina Press. https://pressbooks.pub/leadershipandinfluencingchangeinnursing/

commitment to goals, as well as a high commitment to relationships. The collaborative approach attempts to meet the concerns and priorities of all parties, but trust and willingness for risk are required for this approach to be effective.[26] See Table 7.7e for types of collaborative approaches, potential results, and appropriate uses.

Table 7.7e. Collaborative Approach[27]

Type of Collaborative Approaches	Potential Results	Appropriate Use
• Maximizing use of fixed resources • Working to increase resources • Listening and communicating to promote understanding of others' interests and values • Learning from each other's insight	• Collaboration builds relationships and improves potential for future problem-solving. • Collaboration promotes creative solutions.	• Parties are committed to the process and adequate time is available. • The issue is too important to compromise. • New insights can be beneficial in achieving creative solutions. • There are diverse interests and issues at play. • Participants can be future focused.

26. Wagner, J. (2018). *Leadership and Influencing Change in Nursing*. University of Regina Press. https://pressbooks.pub/leadershipandinfluencingchangeinnursing/

27. Wagner, J. (2018). *Leadership and Influencing Change in Nursing*. University of Regina Press. https://pressbooks.pub/leadershipandinfluencingchangeinnursing/

Application to Nursing

An example of appropriately using the collaborative approach in conflict management in a clinical setting is when discussing vacation time off with team members. During a team meeting, time is available to discuss and focus on what is important and a priority for each member of the team. However, the collaborative approach to conflict management would be inappropriate when discussing the implementation of a new agency policy if the team has little influence in making adjustments.[28]

All approaches to conflict can be appropriate for specific situations, but they can also be inappropriate or overused. When conflict occurs, take time to consider which approach is most beneficial for the situation. Keep in mind that using wrong approaches can escalate conflict, damage relationships, and reduce your ability to effectively meet team goals. Correct conflict management approaches build trust in relationships, accomplish goals, and de-escalate conflict.[29]

Everyone has the capacity to use any of these approaches for managing conflict and can shift from their natural style as needed. We tend to react with our most dominant natural style when under stress, but other approaches can be learned and applied with practice and self-awareness. When dealing with others who have not developed their capacity to shift from their natural style of conflict management, it is important to consider their underlying needs. By understanding individuals' needs existing beneath the surface of

28. Wagner, J. (2018). *Leadership and Influencing Change in Nursing*. University of Regina Press. https://pressbooks.pub/leadershipandinfluencingchangeinnursing/

29. Wagner, J. (2018). *Leadership and Influencing Change in Nursing*. University of Regina Press. https://pressbooks.pub/leadershipandinfluencingchangeinnursing/

the conflict, you can work with the other person toward achieving a common goal.[30]

Addressing Individual Needs and Approaches

There are times when other individuals take an approach that is not helpful to resolving the conflict. It is important to remember the only person you can control during a conflict is yourself. Be flexible with your approach according to the situation and the team members with whom you are working. If someone is taking an approach that is not beneficial to resolving conflict, it can be helpful to try to understand the needs that underlie their decision to take that approach.[31]

Here are some examples of needs underlying their approaches to conflict and suggested ways to address them[32]:

- People using the **avoidance approach** may need to feel physically and emotionally safe. Take the time to reassure them that their needs will be heard.
- People taking the **competitive approach** often feel the need for something to be accomplished to meet their goals. It may be helpful to say, "We will work out a solution, but it may take some time to get there."
- People using the **accommodating approach** may need to know that no

30. Wagner, J. (2018). *Leadership and Influencing Change in Nursing*. University of Regina Press. https://pressbooks.pub/leadershipandinfluencingchangeinnursing/

31. Wagner, J. (2018). *Leadership and Influencing Change in Nursing*. University of Regina Press. https://pressbooks.pub/leadershipandinfluencingchangeinnursing/

32. Wagner, J. (2018). *Leadership and Influencing Change in Nursing*. University of Regina Press. https://pressbooks.pub/leadershipandinfluencingchangeinnursing/

matter what happens during the conversation, your relationship will remain intact. It may be helpful to say, "This decision will not affect our relationship or how we work together."

- People using the **compromising approach** may need to know that they will get something in return. It may be helpful to say, "We will do Action A first, and then we will do Action B for you." However, be sure to be true to your word.
- People using the **collaborative approach** may need to know what you want before they are comfortable sharing their needs. It may be helpful to say, "I need this, this, and this…What do you need?"

> Take free online Conflict Quizzes and Assessments to identify your preferred conflict management styles.

Escalating and De-Escalating Conflict

An approach taken to manage conflict can escalate (increase) or de-escalate (decrease) the conflict. Conflict on a team can take a life of its own and escalate beyond reason if not managed appropriately by nurse leaders. When conflict is not managed appropriately, negative consequences within the team often occur, and client safety can be compromised. Increased rates of absenteeism and turnover may also occur.[33]

33. Children, Youth, Families & Communities & Michigan State University Extension. (2009). *Module 3 | Part 6 – Managing conflict: Escalating and de-escalating.* Michigan State University Board of Trustees. https://www.canr.msu.edu/uploads/236/64484/MOD_3_MANAGING_CONFLICT_ESCALATING_AND_DE-ESCALATING.pdf

Conflict tends to escalate under the following conditions[34]:

- There is an increase in emotions like anger, frustration, etc.
- An individual feels that they are being threatened (i.e., the fight-or-flight response is triggered).
- Other people get involved and choose sides.
- The individuals were not friendly prior to the conflict.
- The individuals desire to engage in conflict.

However, conflict can be de-escalated under the following conditions[35]:

- Attention is focused on solving the problem.
- There is a decrease in emotion and perceived threat.
- The individuals were friendly prior to the conflict.
- The individuals desire to reduce conflict.

Read an example of escalating conflict in the following box.

34. Children, Youth, Families & Communities & Michigan State University Extension. (2009). *Module 3 | Part 6 – Managing conflict: Escalating and de-escalating.* Michigan State University Board of Trustees. https://www.canr.msu.edu/uploads/236/64484/MOD_3_MANAGING_CONFLICT_ESCALATING_AND_DE-ESCALATING.pdf

35. Children, Youth, Families & Communities & Michigan State University Extension. (2009). *Module 3 | Part 6 – Managing conflict: Escalating and de-escalating.* Michigan State University Board of Trustees. https://www.canr.msu.edu/uploads/236/64484/MOD_3_MANAGING_CONFLICT_ESCALATING_AND_DE-ESCALATING.pdf

Example of Escalating Conflict[36]

A conflict begins between two team members who became short-tempered with each other while caring for a client experiencing a medical emergency.

- The parties become aware of the conflict but attempt to deal with it sensibly. Often, they will attribute the problem to "a misunderstanding" and indicate "we can work it out."
- If an appropriate conflict management approach is not used, the parties begin to move from cooperation to competition. ("I'll bend – but only if they bend first.") They begin to view the conflict as resulting from deliberate action on the part of the other. ("Didn't they know this was going to happen?") Positions begin to harden and defensiveness sets in, creating adversarial encounters. Parties begin to strengthen their positions and look to others on the team for support. ("Don't you feel I'm being reasonable?" or "Did you know what that idiot did to me?")
- As communication deteriorates, parties rely on assumptions about the other individual and attribute negative motives to them. ("I bet they did that on purpose.") Groupthink can take over the subgroups as each individual seeks others to take on their side. ("We have to appear strong and make a united front.")
- Parties believe that cooperation cannot resolve the

36. The Center for Congregational Health. (2011). *Levels of conflict by Speed Leas.* https://cntr4conghealth.wordpress.com/2011/09/01/levels-of-conflict-by-speed-leas/

problem because of the assumed negative actions of the other. ("I've tried everything to get them to see reason," "It's time to get tough," or "I'm going to put a stop to this.")

- Parties begin to feel righteous and blame the other for the entire problem. Generalizing and stereotyping begin. ("I know what those kinds of people are like. . . We can't let them get away with this.") Parties begin to be judgmental and moralistic and believe they are defending what is "right." ("It's the principle of the matter" or "What will others say if we give in to this?")
- Severe confrontation is anticipated and planned, thus making it inevitable. The parties view this confrontation as acceptable. The objective of the conflict becomes to hurt the other more than being hurt, and the dispute is beyond rational analysis. ("I'm going to make you pay even if we both go down over this," "There is no turning back now," or "They won't make a fool out of me.")

There are positive steps to take to de-escalate conflict with another individual before it gets out of control. See Figure 7.9[37] for steps to de-escalate conflict and implement change.

37. "Dispute Resolution Office, Ministry of Justice (Government of Saskatchewan)" designed by JVDW Designs, is licensed under a CC BY 4.0 International License

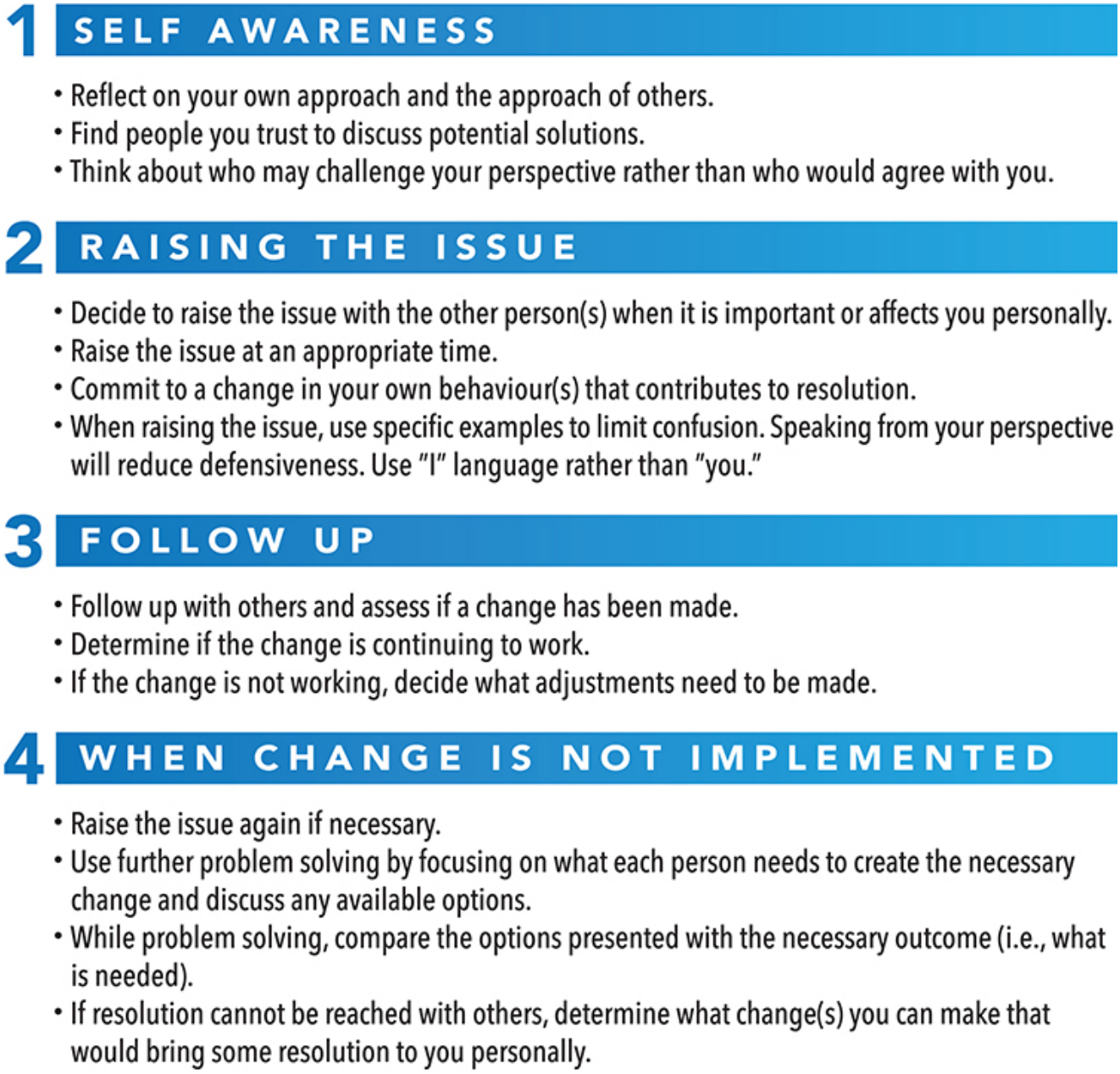


Figure 7.9 Steps to De-Escalate Conflict

Conflict Management Tips

Nurses must develop their own tool kit to manage conflict in a productive, positive way. Due to rapid turnover in the health care environment at this time, new nurses may find themselves in a "charge nurse" position within

their first year of practice. See Table 7.7f for tips on managing conflict constructively.[38]

Table 7.7f. Conflict Management Tips[39]

38. Elizabeth, A. (2019). Managing interpersonal conflict: Steps for success. *Nursing Management, 50*(6), 22-28. https://journals.lww.com/nursingmanagement/Fulltext/2019/06000/Managing_interpersonal_conflict__Steps_for_success.7.aspx

39. Elizabeth, A. (2019). Managing interpersonal conflict: Steps for success. *Nursing Management, 50*(6), 22-28. https://journals.lww.com/nursingmanagement/Fulltext/2019/06000/Managing_interpersonal_conflict__Steps_for_success.7.aspx

Tip	Description
Be Consistent	Convey to the team that expectations are consistent and implemented fairly across the team. Set expectations and make sure the team knows those expectations via department meetings and visual reminders. Follow up to ensure expectations are met. This sets a clear picture of what is required.
Be Team-Focused	Be aware of team members' strengths and weaknesses. Address poor performance and negative attitudes. Teamwork and team dynamics impact client safety and staff retention. Ask team members what they need from you as a leader. Coach team members and staff on a regular basis.
Convey Trust and Integrity	Trustworthiness and integrity are powerful when managing conflict. Team members are more likely to handle difficult situations constructively if they know they are supported by an approachable and supportive team leader. Stay focused on the individual and remind them that you value them and want them to feel heard. It may be helpful to include a statement such as, "As health care members, we are held accountable for positive behaviors with team members."
Lead with Truth	If you need to have a difficult conversation, lead with the tough message and be clear. For example, try saying, "There's something difficult I need to talk with you about. I'm concerned about the feedback I've been receiving from clients." Even in conveying a tough message, you can build trust by showing the employee that you'll be honest with them and share feedback openly. Don't leave the team member guessing about the problem or what they need to do to improve. Clearly state the performance gap, your expectations, the reason it matters, and the timeline for improvement, including a future meeting to review feedback and give a progress update. Provide support and available resources to help them make the needed change.

Anticipate Reactions	Knowing how a team member will respond when conflicts arise can be a challenge. Common negative reactions to conflicts are defensiveness, deflection, and denial. Defensive comments may include, “No one’s ever brought this to me before.” You can reply, “I’m invested in you and want to see you succeed. I owe it to you and our department to be transparent with you and share these concerns.” Deflection can take the form of an employee asking you why a coworker didn’t directly bring up the concern. Often, it’s because others are too intimidated by the individual or situation to speak up. Your reply can be, “Accountability between colleagues is always encouraged, but as your leader, I owe it to you to share this feedback. Do you feel your colleagues perceive you as approachable and open to feedback?” Denial may include the employee refuting that the incident of concern ever happened. You can calmly remind the employee that we own others’ perceptions of our behaviors and you want to help them understand where some actions may be giving people the wrong impression.
Use Available Resources	Engage in professional development for managing conflicts when they arise. Share knowledge and experiences with other nurse leaders to build networks, partner with other teams within the organization, and use the human resources department when needed.

7.8 Nursing Responsibilities in Interprofessional Collaborative Practice

Previous sections of this chapter 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 client 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.

Reflective Activity

View the following YouTube video illustrating an interdisciplinary

care conference as a client's plan of care is designed and implemented.[1]

Interprofessional Professionalism Collaborative

Reflective Questions[2]:

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 client and how the care is continued through multidisciplinary involvement.
2. Assess interprofessional collaborative practice of the health care team using the following PDF:

Interprofessional Professionalism Assessment Tool

Assigning, Delegating, and Supervising

Nurses assign, delegate, and supervise care of other members of the nursing team, such as licensed practical/vocational nurses (LPN/VN) and unlicensed assistive personnel (UAP). Appropriately assigning and delegating care with appropriate supervision are strategies that ensure quality client care is completed efficiently. Read more about assigning and delegating in the "Delegation and Supervision" chapter.

1. Interprofessional Professionalism Collaborative. (2018, August 15). *IPC case scenario for Mr. Jones part I* [Video]. YouTube. All rights reserved. https://youtu.be/woHaclEtLFw

2. Interprofessional Professionalism Collaborative. (2019). *IPA tool kit*. http://www.interprofessionalprofessionalism.org/toolkit.html

Educating Clients and Staff

Nurses provide client education, train staff, and serve as a staff resource. For example, an RN serves as a resource to unlicensed assistive personnel (UAP) 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 UAP's assigned tasks, and shares how the staff interact and communicate within the unit. The RN ensures the UAP 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.[3] Read more about nurse advocacy in the "Advocacy" chapter.

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,

3. Gerber, L. (2018). Understanding the nurse's role as a patient advocate. *Nursing, 48(*4), 55-58. https://journals.lww.com/nursing/Fulltext/2018/04000/Understanding_the_nurse_s_role_as_a_patient.15.aspx

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."[4] 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[5]

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

4. Kim, S. Y. (2017). Continuity of care. *Korean Journal of Family Medicine, 38*(5), 241. https://doi.org/10.4082/kjfm.2017.38.5.241

5. Medication Safety in Transitions of Care by World Health Organization is licensed under CC BY-NC-SA 3.0

- 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 client and verifying with at least one reliable information source, reconciling and updating the medication list, and communicating with the client 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.

Safely Admitting and Discharging Clients

Admission refers to an initial visit or contact with a client. **Discharge** refers to the completion of care and services in a health care facility and the client is sent home (or to another health care facility).

Admissions and discharges are more than just the physical movement of an individual. They require a great deal of confidential information sharing to maintain continuity of care. During an admission, nurses use the nursing process to thoroughly assess the client, diagnose nursing problems, establish expected outcomes, and create a nursing care plan. Referrals for other inpatient services, such as a dietician, wound care nurse, chaplain, social worker, or other interprofessional team members, may be initiated. Additionally, the client and their family members are oriented to the setting, and information is provided regarding HIPAA and client rights and

responsibilities; medications are reconciled; and other admission tasks are completed based on agency policy.

During discharge, there is also a great deal of information shared with clients regarding follow-up appointments with interprofessional team members, medication reconciliation, and client education.

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 client'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 client 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.

7.9 Spotlight Application

Allison is a new graduate nurse who is recently transitioned from her orientation period to her scheduled night shift work on a medical telemetry unit. She has a client care assignment of six client. Her client, Mr. Daniels, was admitted from the ER at 2200 shortly before her shift began. He was transferred to the floor with a medical diagnosis of heart failure exacerbation. The client was prescribed IV push furosemide for diuresis. It is now 0500 and the client's morning potassium level is reported from the lab to be 2.9 mmol/L. Allison understands that this level needs to be reported to the admitting physician. Utilizing an ISBARR format, what information should Allison be prepared to phone the physician?

Allison should be prepared to tell the physician her role on the unit and that she is calling to relate information on a critical lab value. She should describe information about the client, including Mr. Daniel's name, position on the unit, and a reminder of when the client was admitted. She should provide a brief synopsis of the stability of the client. If there is relevant information regarding allergies, this should be related at this time as well. The concern related to the lab value and any accompanying symptoms should also be described. Allison should provide insight into the current intake and output status, weight, cardiac rhythm, signs of edema, respiratory status, etc. Allison should outline her request related to orders for potassium replacement. When these orders are received from the provider, she must be sure to repeat back the order to confirm accuracy.

Learning Activities

(Answers to "Learning Activities" can be found in the "Answer Key" at the end of the book. Answers to interactive activities are provided as immediate feedback.)

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

Scenario 1

Read this scenario and answer the following questions.

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

On one of his rounds, Neil attends to his client in Room 8. He reads the chart and notices Jill's initials signaling that she had already checked on this client. A bit confused, he continues on to his next client. After another hour goes by, Neil returns to Room 8 and again notices Jill's initials on the chart. Neil thinks to himself, "What is she doing? I've got it covered. She's checking my work. She must think I'm incompetent." Neil decides to approach Jill and see what is going on.

Questions:

a) What might have been the initial cause of the conflict?

b) What kind of conflict did it turn into?

c) If Neil provides Jill with a copy of the room assignments, would that resolve the conflict?

Scenario 2

Read this scenario and answer the following questions.

A nursing team is having a routine meeting. One of the nurses, Stephen, is at the end of a 12-hour shift, and another nurse, Tanya, is just beginning hers. 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 is seen rolling his eyes and talking to other members of the team. Tanya breaks from her presentation and asks, "Stephen, do you have 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 if he had anything to add from the meeting. Stephen replies, "No, I don't have anything. 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."

Questions:

a) What types of conflict are present?

b) What will need to happen to resolve this issue between Tanya and Stephen?

c) Take a moment to think about what your preferred approach to conflict may be. How might you adapt your approach to conflict when working with others?

Scenario 3

Read this scenario and answer the following questions.

Connie, the head nurse on Unit 7, 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 clients 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 clients.

Connie is four hours into her 12-hour shift when she is approached by Dr. Smith. He asks, "Connie, why has the client 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 client had been missing medication. I'll go check on it and get back to you."

Dr. Smith is persistent, saying, "You don't need to go check anything. I know this client 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 somewhere . . .”

“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 where Dan and Elise are assessing charts and says to them, “You will not believe what Dr. Smith just said to me!”

Dan and Elise look shocked and ask “What?”

Connie explains, “Well, he thinks I don’t do my job, when really we nurses are the ones that keep this unit going. Who is he to question my ability to look after clients? I am the most knowledgeable person on this unit!”

Dan and Elise don’t know how to reply and decide to avoid the interaction with a simple, “Oh yeah.”

Meanwhile, Dr. Smith has made his way to the doctor’s lounge and finds his colleague Dr. Lee. Dr. Smith tells him, “That head nurse on Unit 7 is useless. She doesn’t know what she is doing and doesn’t understand that we must be informed about changes to our clients’ medications, does she?” Dr. Lee nods quickly and returns to reviewing his file.

About three hours later, Connie and Dr. Smith have each spoken to several people about the interaction. Connie bumps into another nurse, Jessie, one of her best friends. Connie pulls Jessie aside and says, “You will not believe what I just saw. I was going into the admin office to file my holiday requests and out of the corner of my eye, I saw Dr. Smith lurking around the corner, pretending to look at a chart, spying on me!”

"What? Are you serious? That's not safe," replies Jessie.

Connie is relieved that Jessie is taking her side—it makes her feel as if she is not going crazy. "Yeah, I'm really getting worried about this. First, that creep is accusing me of not doing my job, and then he is wasting his time spying on me. What a loser! Maybe what I should do is file a complaint. That'll show the 'big man' that he isn't that big around here and maybe take him down a notch."

When Jessie gives her an apprehensive look, Connie continues, "Oh Jessie, don't worry. I have a perfect record and this won't affect me. Even if it does, I will have done something good for all the other nurses around here. It is the principle of the matter at this point."

Meanwhile, Dr. Smith has run into an old classmate of his, Dr. Drucker, and says, "Wow! You got hired! So happy to have you in the hospital. I do need to tell you though to be careful of the head nurse on Unit 7 . . ." Dr. Smith describes his troubles with Connie and adds, "She's a real snitch! She makes trouble out of nothing. I was reviewing a chart down the corridor from the admin office, minding my own business and actually getting my work done, when I saw her slip into the admin office to squeal about me to the top bosses! This is something that needs to be watched! We can't have people reporting doctors to administration over nothing. I think I'm going to write her up and get a black mark on that perfect record of hers. I will be fine—everyone knows I'm right. There will be consequences for her."

Questions:

a) Using the scenario above, identify the stages of the conflict escalation.

b) What suggestions might you give to Dan, Elise, Jessie, Dr. Lee, and Dr. Drucker about how to respond to Connie and Dr. Smith?

c) How do you think this conflict will be resolved?

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https://wtcs.pressbooks.pub/nursingmpc/?p=1061#h5p-28

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nursingmpc/?p=1061#h5p-29

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nursingmpc/?p=1061#h5p-30

Test your knowledge using this NCLEX Next Generation-style Case Study. You may reset

- and resubmit your answers to this question an unlimited number of times.[1]

1. “Chapter 7, Assignment 1” by Travis Christman for OpenRN is licensed under CC BY-NC 4.0

VII Glossary

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

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

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

Communication conflict: Occurs when there is a failure in the exchange of information.

Continuity of care: The use of information on past events and personal circumstances to make current care appropriate for each individual.[1]

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.[2]

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

1. Kim, S. Y. (2017). Continuity of care. *Korean Journal of Family Medicine, 38*(5), 241. https://doi.org/10.4082/kjfm.2017.38.5.241

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

These assertive statements are “I am Concerned – I am Uncomfortable – This is a Safety issue!”[3]

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.

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).

Ethical conflict: Occurs when individuals or groups have fundamentally different beliefs 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.[4]

Goal conflict: Happens when the objectives of individuals or groups are incompatible.

Handoff reports: A transfer and acceptance of client care responsibility achieved through effective communication. It is a real-time process of passing client specific information from one caregiver to another, or from one

3. AHRQ. (2024). TeamSTEPPS: 3.0 Pocket guide. https://www.ahrq.gov/teamstepps-program/resources/pocket-guide/index.html

4. AHRQ. (2024). TeamSTEPPS: 3.0 Pocket guide. https://www.ahrq.gov/teamstepps-program/resources/pocket-guide/index.html

team of caregivers to another, for the purpose of ensuring the continuity and safety of the client's care.[5]

Horizontal aggression: Hostile behavior among one's peers.

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 client 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.

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 clients, 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.

5. Starmer, A. J., Spector, N. D., Srivastava, R., Allen, A. D., Landrigan, C. P., Sectish, T. C., & I-Pass Study Group. (2012). I-PASS, a Mnemonic to Standardize Verbal Handoffs. *Pediatrics, 129*(2), 201-204. https://www.ipassinstitute.com/hubfs/I-PASS-mnemonic.pdf

ISBARR: A mnemonic for the components of Introduction, Situation, Background, Assessment, Request/Recommendations, and Repeat back.[6,7]

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

Personality conflict: Arises from differences in individual temperaments, attitudes, and behaviors.

Role conflict: Arises when individuals have multiple, often conflicting, expectations associated with their roles.

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.[8]

Situation awareness: The awareness of a team member knowing what is going on around them.[9]

Situation monitoring: The process of continually scanning and assessing the

6. Institute for Healthcare Improvement (n.d.). ISBAR trip tick. https://www.ihi.org/resources/tools/sbar-tool-situation-background-assessment-recommendation

7. Grbach, W., Vincent, L., & Struth, D. (2008). *Curriculum developer for simulation education*. QSEN Institute. https://qsen.org/reformulating-sbar-to-i-sbar-r/

8. AHRQ. (2024). TeamSTEPPS 3.0. https://www.ahrq.gov/teamstepps/instructor/index.html

9. AHRQ. (2024). TeamSTEPPS 3.0. https://www.ahrq.gov/teamstepps/instructor/index.html

situation to gain and maintain an understanding of what is going on around you.[10]

STEP tool: A situation monitoring tool used to know what is going on with you, your clients, your team, and your environment. STEP stands for Status of the clients, Team members, Environment, and Progress Toward Goal.[11]

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.[12]

Two-challenge rule: A strategy for advocating for client 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.

10. AHRQ. (2024). TeamSTEPPS 3.0. https://www.ahrq.gov/teamstepps/instructor/index.html
11. AHRQ. (2024). TeamSTEPPS 3.0. https://www.ahrq.gov/teamstepps/instructor/index.html
12. AHRQ. (2024). TeamSTEPPS 3.0. https://www.ahrq.gov/teamstepps/instructor/index.html

PART VIII

CHAPTER 8 - HEALTH CARE ECONOMICS

8.1 Health Care Economics Introduction

Learning Objectives

- Summarize the requirements of funding and reimbursement sources for client care services
- Explore how political, social, and demographic trends have affected the client population and delivery of health care
- Analyze the link between economics and quality
- Describe nursing strategies to provide cost-effective care
- Examine economic pressures impacting case management and the management of institutional resources
- Describe the impact of evidence-based practice on health care economics and client care outcomes

Whether health care is a right or a privilege is a historical ethical question debated around the world that ultimately leads to the question, "Who gets what resources?" **Economics** is the study of how individuals and societies make decisions about how to use their limited resources. Health care is considered a limited resource because there isn't enough money or time in the world to purchase and provide care for every individual in every conceivable manner. The ethical question of who pays for that care is referred to as the ethics of rationing health care.

Economics is split into two broad categories called macroeconomics and microeconomics. Macroeconomics looks at decisions that affect the entire society as a whole, whereas microeconomics looks at the financial decisions

of businesses and individuals.[1] This chapter will provide an overview of the broad topics of health care funding and reimbursement models at a societal level, as well as staffing and budgeting issues at the institutional level that impact nurses in their day-to-day work. Economics in health care affects an individual's ability to pay for and receive health care, the ability of an institution to provide health care services, and nurses' ability to provide safe, quality care to the communities they serve.

1. Khan Academy. (2017, August 8). *Macroeconomics unit: Basic economics concepts*. https://www.khanacademy.org/economics-finance-domain/macroeconomics/macro-basic-economics-concepts

8.2 Trends Related to Increased Health Care Costs

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.[1] U.S. health care spending grew 4.1 percent in 2022, reaching $ 4.5 trillion or $13,493 per person. Health care spending accounts for 17.3 percent of our Gross Domestic Product (GDP), the total value of goods produced and services provided annually.[2] See Figure 8.1[3] for a graph of health care cost as a percentage of GDP in the United States compared to other countries around the world.

1. CMS.gov. (2024). *National health expenditure data – historical*. Centers for Medicare & Medicaid Services. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical

2. CMS.gov. (2024). *National health expenditure data – historical*. Centers for Medicare & Medicaid Services. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical

3. "Health_Care_Cost_as_Percentage_of_GDP.png" by Delphi234 is licensed under CC0 1.0

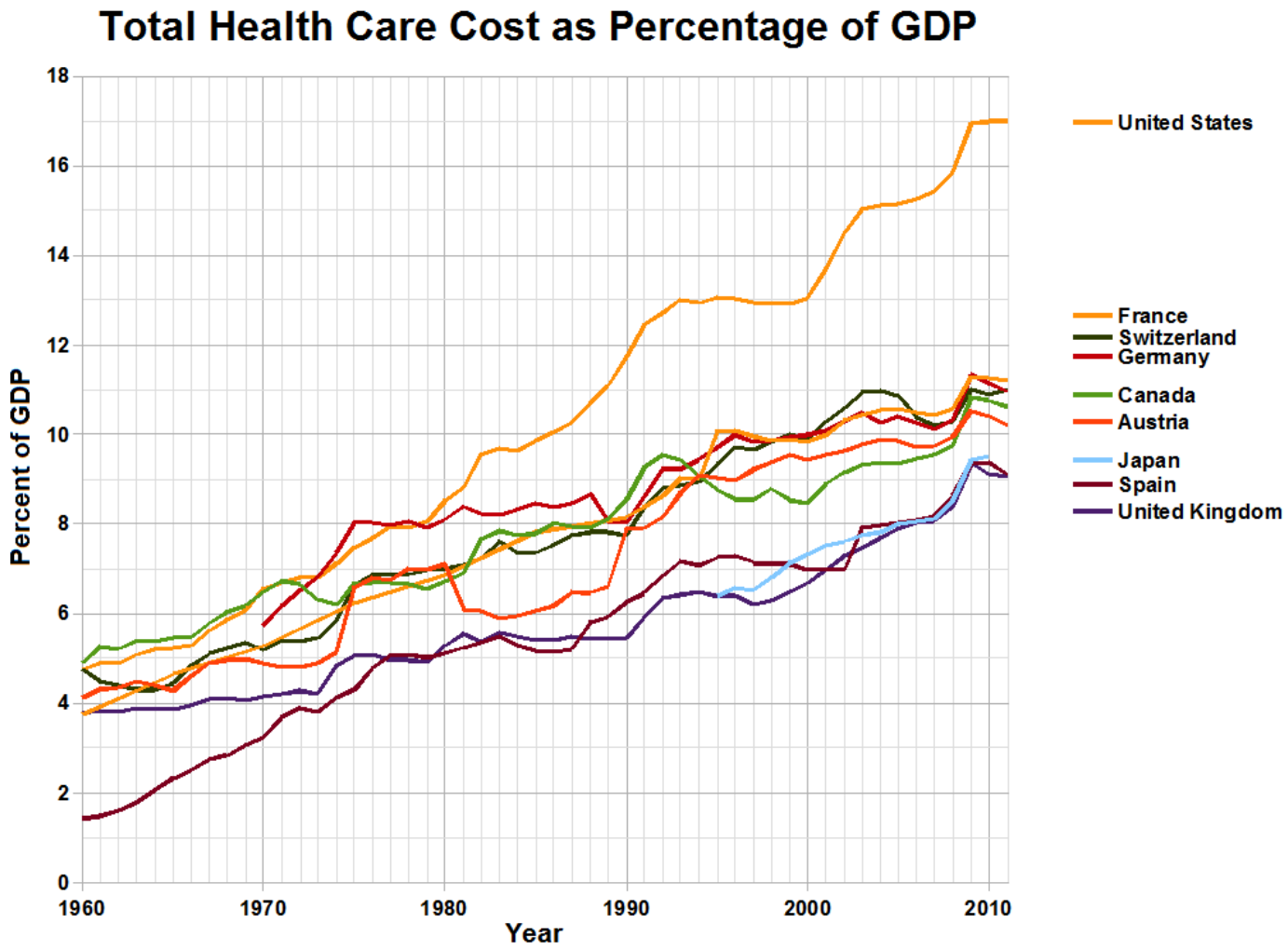


Figure 8.1 Comparison of Health Care Costs

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.[4] The increasing costs of health care also have several negative impacts on society, employers, and individuals, including the following effects[5]:

4. Bush, M. (2018). Addressing the root cause: Rising health care costs and social determinants of health. *North Carolina Medical Journal, 79*(1), 26-29. https://doi.org/10.18043/ncm.79.1.26

5. Schreck, R. I. (2020). Overview of health care financing. *Merck Manual*

- 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, social determinants of health, etc. These trends can be further classified as intrinsic or extrinsic factors. **Intrinsic factors** related to increased health care costs are inherent to the characteristics and needs of the population. One significant intrinsic factor is the demographics of the population, such as age, gender, and overall health status. An aging population, for example, typically requires more medical care due to the prevalence of chronic conditions and the natural decline in health associated with aging. Another intrinsic factor is the demand for health care services. As people become more health-conscious, the demand for preventive care, regular check-ups, and advanced

Consumer Version. https://www.merckmanuals.com/home/fundamentals/financial-issues-in-health-care/overview-of-health-care-financing

treatments rises, leading to increased overall health care spending. Additionally, the extent and nature of health insurance coverage play a crucial role. Comprehensive insurance plans often lead to higher utilization of health care services, as insured individuals are more likely to seek medical care, knowing that a significant portion of the costs will be covered by their insurance.

Extrinsic factors are external elements that impact health care costs. One of the most prominent extrinsic factors is the availability and adoption of medical technology. Advanced diagnostic tools, treatment methods, and surgical techniques can drive up costs due to their high development, implementation, and maintenance expenses. While these technologies can significantly improve client outcomes, they also contribute to rising health care expenditures. Another critical extrinsic factor is the cost of prescription drugs. Pharmaceutical pricing strategies, including research and development costs, marketing, and profit margins, often lead to high prices for medications, especially for new and specialized drugs. Workforce costs are also a significant extrinsic factor. The salaries and benefits of health care professionals, including doctors, nurses, and administrative staff, constitute a substantial portion of health care expenses. These costs are influenced by factors such as education and training requirements, labor market conditions, and regulatory policies. Addressing these extrinsic factors requires strategic planning and policy interventions to balance cost containment with the quality and accessibility of health care services.

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.[6] See

6. Agency for Healthcare Research and Quality. (n.d.). *Elderly.* https://www.ahrq.gov/topics/elderly.html

Figure 8.2[7] 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.[8]

7. "graying-america-aging-nation.jpg" by U.S. Census Bureau is in the Public Domain

8. Agency for Healthcare Research and Quality. (n.d.). *Elderly*. https://www.ahrq.gov/topics/elderly.html

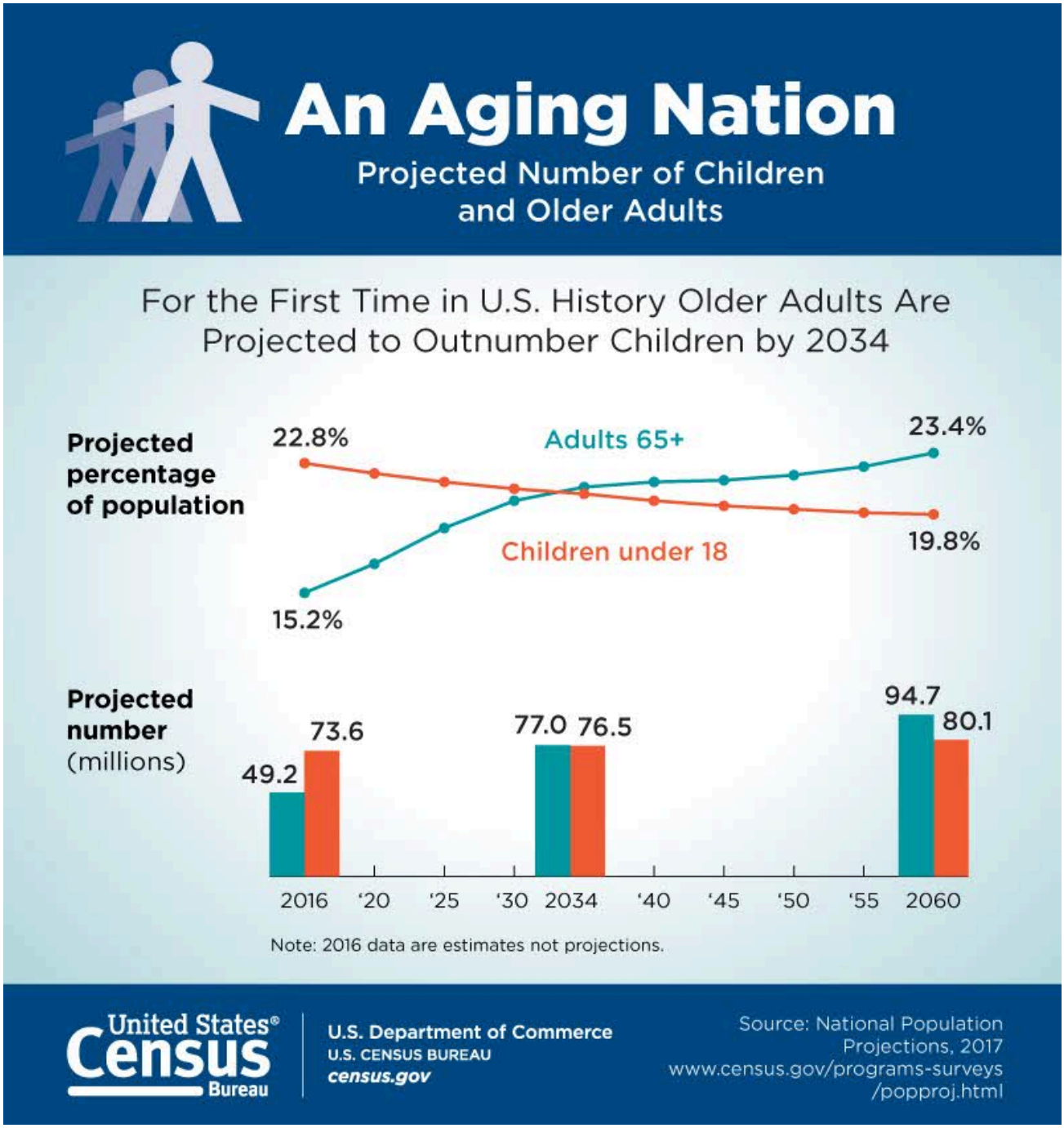


Figure 8.2 Aging Population in the United States

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.[9] These costs also lead to further ethical dilemmas as decisions regarding what scarce resources are provided to which clients are made. See Figure 8.3[10] for an image of common technology used in health care.



Figure 8.3 Health Care Technology

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

9. Neumann, P. J., & Weinstein, M. C. (1991). The diffusion of new technology: Costs and benefits to health care. In Institute of Medicine (US) Committee on Technological Innovation in Medicine, Gelijns, A. C., & Halm, E. A. (Eds.). *The changing economics of medical technology*. National Academies Press. https://www.ncbi.nlm.nih.gov/books/NBK234309/

10. "49458105981_fe87fd521c_o.jpg" by Wonderlane is licensed under CC BY 2.0

improves health outcomes at a lower cost than existing technologies, it should be adopted; otherwise, it should not.[11]

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.[12] For example, the cost of Symbicort, a medication used to treat asthma and COPD, increased 46 percent, from

11. Neumann, P. J., & Weinstein, M. C. (1991). The diffusion of new technology: Costs and benefits to health care. In Institute of Medicine (US) Committee on Technological Innovation in Medicine, Gelijns, A. C., & Halm, E. A. (Eds.). *The changing economics of medical technology.* National Academies Press. https://www.ncbi.nlm.nih.gov/books/NBK234309/

12. Bunis, D. (2021). *Prescription drug price increases continue to outpace inflation*. AARP. https://www.aarp.org/politics-society/advocacy/info-2021/prescription-price-increase-report.html

$2,940 to $4,282.[13] See Figure 8.4[14] for an illustration related to prescription medication costs.

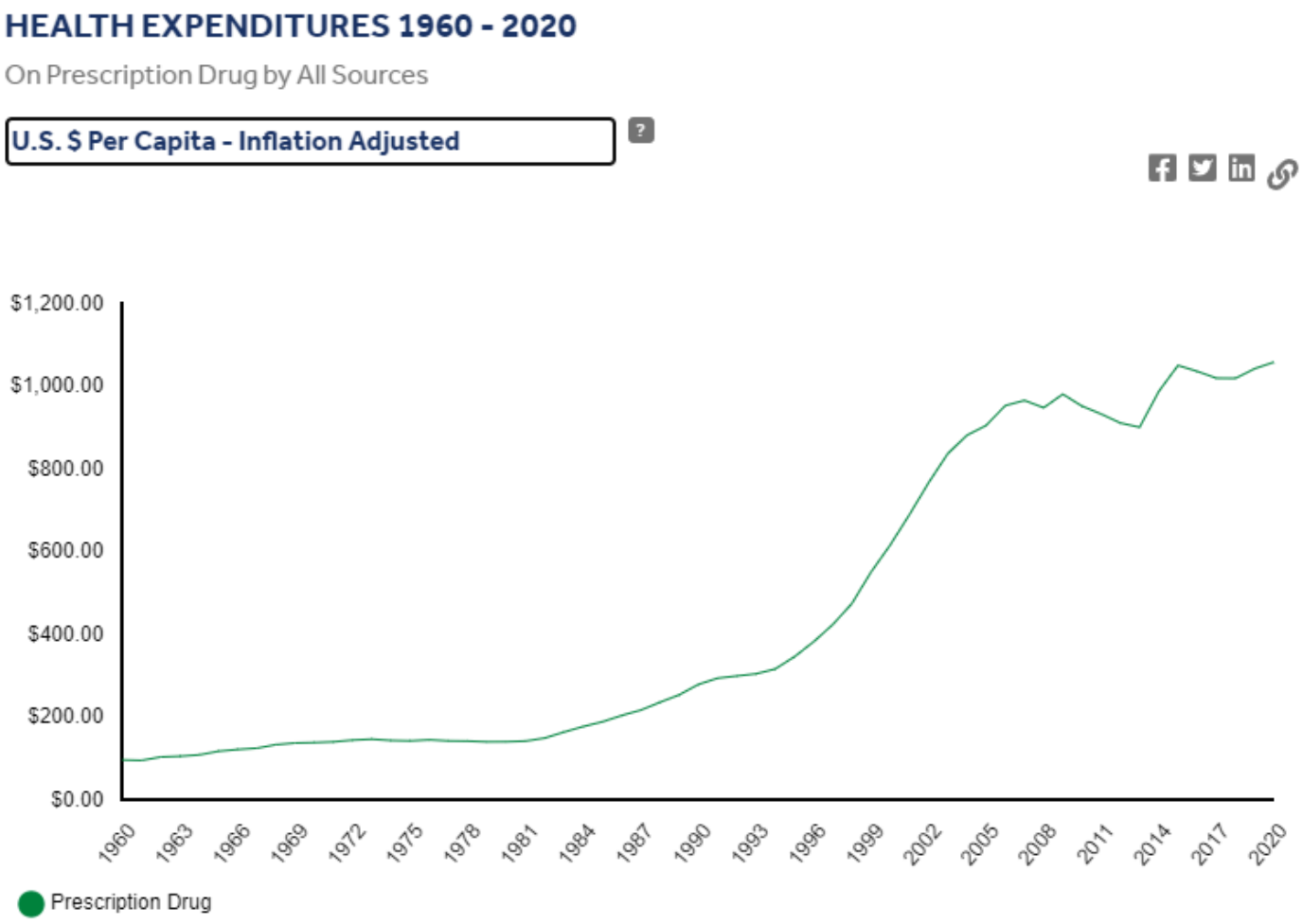


Figure 8.4 Prescription Medication Costs

13. Bunis, D. (2021). *Prescription drug price increases continue to outpace inflation*. AARP. https://www.aarp.org/politics-society/advocacy/info-2021/prescription-price-increase-report.html

14. Peterson_KFF Health Systems Tracker. (n.d.). *Health expenditures 1960-2020*. https://www.healthsystemtracker.org/health-spending-explorer/?outputType=%24pop-adjusted&serviceType%5B0%5D=prescriptionDrug&serviceType%5B1%5D=hospitals&serviceType%5B2%5D=allTypes&sourceOfFunds%5B0%5D=allSources&tab=0&yearCompare%5B0%5D=%2A&yearCompare%5B1%5D=%2A&yearRange%5B0%5D=%2A&yearRange%5B1%5D=%2A&yearSingle=%2A&yearType=range

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.[15]

Many consumers find themselves tasked with the difficult decision of purchasing expensive medication or going without prescribed medication and paying 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

15. Bunis, D. (2021). *Prescription drug price increases continue to outpace inflation*. AARP. https://www.aarp.org/politics-society/advocacy/info-2021/prescription-price-increase-report.html

the ACA and associated Medicaid expansion, 32 million people had health care coverage in 2021.[16]

> Read about the Affordable Care Act at HHS.gov.

Key Provisions of the ACA

The ACA includes the following key provisions[17]:

- 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

16. HealthCare.gov. *Insurance marketplace*. https://www.healthcare.gov/subscribe/?gclid=Cj0KCQjwiqWHBhD2ARIsAPCDzamNRkS3URx_uUvJGdpX15DrZnVbBadXbPmOjBBlLyjtZBn7cLei6WEaAl8GEALw_wcB&gclsrc=aw.ds

17. HHS.gov. *About the Affordable Care Act.* U.S. Department of Health & Human Services. https://www.hhs.gov/healthcare/about-the-aca/index.html

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.[18]

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

18. K&L Gates LLP, Carnevale, A., Hamscho, V., Lawless, T., & Sha Page, K. (2021). *The Affordable Care Act survives Supreme Court challenge: What happens next?* JD Supra. https://www.jdsupra.com/legalnews/the-affordable-care-act-survives-3115372/

medication pricing reform and expanding Medicare eligibility age and benefits.[19]

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.[20]

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.[21]

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

19. K&L Gates LLP, Carnevale, A., Hamscho, V., Lawless, T., & Sha Page, K. (2021). *The Affordable Care Act survives Supreme Court challenge: What happens next?* JD Supra. https://www.jdsupra.com/legalnews/the-affordable-care-act-survives-3115372/

20. Healthy People 2030. (n.d.). *Social determinants of health*. U.S. Department of Health and Human Services. https://health.gov/healthypeople/objectives-and-data/social-determinants-health

21. Bush, M. (2018). Addressing the root cause: Rising health care costs and social determinants of health. *North Carolina Medical Journal. 79*(1), 26-29. https://www.ncmedicaljournal.com/content/79/1/26

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."[22] Nurses act in many ways to address these priorities as they advocate for individuals, families, and communities.

▶ Read more about efforts addressing SDOH for improved economic stability and health care access in Healthy People 2020.

SDOH Case Study

Maria's Journey Through the Health Care System *(Answers are located in the answer key at the back of the book)*

Maria, a 45-year-old woman, lives in a low-income neighborhood in a large urban area. She works two part-time jobs to support her family of four and has limited access to health care due to financial constraints and transportation issues. Maria has been diagnosed with type 2 diabetes, and her health care outcomes are significantly influenced by various Social Determinants of Health (SDOH).

Maria's low income and unstable employment contribute to her inability to afford healthy food, medications, and regular medical check-ups. This economic instability exacerbates her diabetes, as she often skips doses of her medication to save money and cannot afford nutritious meals that would help manage her condition. The constant stress of making ends meet and

22. Healthy People 2030. (n.d.). *Social determinants of health.* U.S. Department of Health and Human Services. https://health.gov/healthypeople/objectives-and-data/social-determinants-health

providing for her family leads to increased cortisol levels, which can negatively impact her blood sugar control.

1. How can Maria's financial stress impact her ability to manage her diabetes effectively?

2. What programs or policies could be implemented to assist individuals like Maria in managing their health care costs?

Maria has limited knowledge about diabetes management due to a lack of education and access to health information. This impacts her ability to understand and implement lifestyle changes or adhere to treatment plans. With limited education, Maria struggles to find better-paying jobs that could provide health insurance and more financial stability.

3. In what ways can improved health literacy impact Maria's diabetes management?

4. What community resources could be made available to enhance health education for individuals in Maria's situation?

The availability of health care services in Maria's neighborhood is limited, with long wait times and fewer specialists. This results in delayed diagnoses and treatments for her diabetes-related complications. Maria lacks comprehensive health insurance, making it difficult for her to access primary and specialist care. High out-of-pocket costs deter her from seeking regular medical attention.

5. How does the lack of accessible health care services affect Maria's long-term health outcomes?

6. What are some potential solutions to improve health care access in underserved areas?

Maria lives in a food desert with limited access to fresh fruits and vegetables. She often relies on inexpensive, processed foods that

worsen her diabetes. Public transportation in Maria's area is unreliable, making it challenging for her to attend medical appointments. This lack of transportation contributes to missed check-ups and unmanaged diabetes.

7. How does living in a food desert affect Maria's ability to manage her diabetes?

8. What transportation initiatives could help individuals like Maria access healthcare services more easily?

Maria has a limited social network and lacks support from friends and family, which is crucial for managing a chronic condition like diabetes. This isolation can lead to depression and further neglect of her health. Living in a high-crime area, Maria feels unsafe walking outside for exercise, which is essential for diabetes management. This sedentary lifestyle negatively affects her health outcomes.

9. How does a lack of social support contribute to Maria's health challenges?

10. What community programs or interventions could be implemented to enhance social support and safety in high-crime areas?

8.3 Health Care Funding

Health care costs impact both macroeconomics (affecting the entire country and society as a whole) and microeconomics (affecting the financial decisions of businesses and individuals). Health care services are funded by several payment models, including federal government programs (e.g., Medicare and Medicaid), private health insurance (typically provided by employers), and self-pay. Payment models also impact services provided by health care agencies, as well as the services and medications available to consumers. Nurses must be aware of these payment models because of the impact on the allocation of resources they need to provide client care.

Government Funding

Medicare and Medicaid were signed into law in 1965. These programs provide eligible Americans support for their health care needs with taxpayer funding.

Medicare

Medicare is 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 kidney transplantation. Medicare coverage has four possible components: Part A, Part B, Part C, and Part D.[1] See Figure 8.5[2] for an infographic illustrating Medicare Parts A, B, C, and D.

- **Part A (Hospital Insurance):** Part A covers clients' hospital stays, skilled nursing facility care, hospice care, and some home health care. Part A is free for clients if they or their spouse paid Medicare taxes for a specific

1. Medicare.gov. *What's Medicare?* https://www.medicare.gov/what-medicare-covers/your-medicare-coverage-choices/whats-medicare

2. "Understanding_of_medicare.png" by Samreen Al is licensed under CC BY-SA 4.0

amount of time while working. If clients are not eligible for free coverage, they can buy it with premiums based on the number of months they paid Medicare taxes.

- **Part B (Medical Insurance):** Part B covers doctors' services, outpatient care, medical supplies, and preventative care services. Most people pay a standard premium for Part B.
- **Part C (Medicare Advantage Plan):** A Medicare Advantage Plan is a health plan choice offered by private companies approved by Medicare, also referred to as "Part C." These plans provide Part A and Part B coverage, and most also include Part D coverage. Medicare Advantage Plans may offer extra coverage, such as vision, hearing, dental, and/or health and wellness programs.
- **Part D (Prescription Drug Coverage):** Part D helps cover the cost of prescription drugs and vaccinations. To get Medicare drug coverage, clients must enroll in a Medicare-approved plan that offers drug coverage. Different plans vary in cost and what prescription medications they cover, also referred to as a formulary.

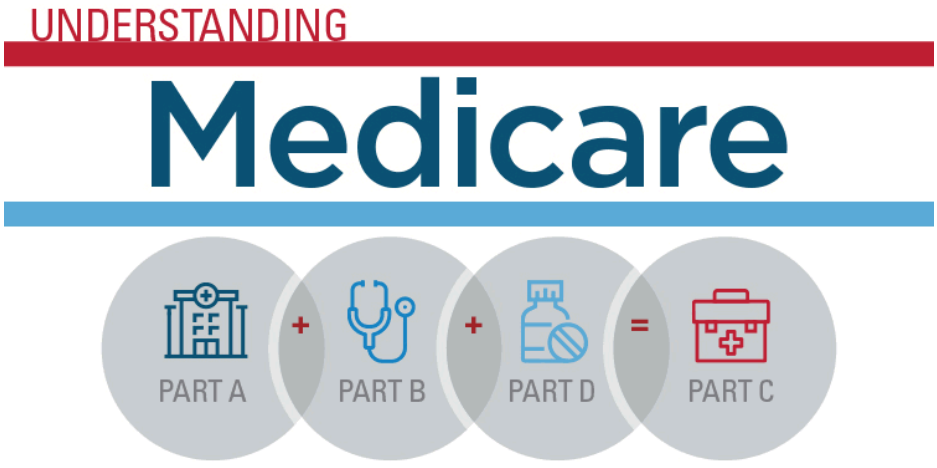


Figure 8.5 Medicare

Read more about Medicare at medicare.gov.

Medicaid

Medicaid is the largest source of health coverage in the United States. It is a joint federal and state program covering eligible individuals with taxpayer funding. To participate in Medicaid, federal law requires states to cover certain groups of 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.[3]

In 2014 the Affordable Care Act expanded Medicaid to cover all low-income Americans under the age of 65 years and also expanded coverage for children. Due to the individual states' involvement in Medicaid, coverage of services varies from state to state.[4] See Figure 8.6[5] for an illustration of Medicaid-eligible populations.

3. Medicaid.gov. *Eligibility*. https://www.medicaid.gov/medicaid/eligibility/index.html

4. Healthcare.gov. *Affordable Care Act*. https://www.healthcare.gov/glossary/affordable-care-act/

5. "Medicaid.expansion-1200×846.png" by KFF is licensed under CC BY-NC-ND 4.0

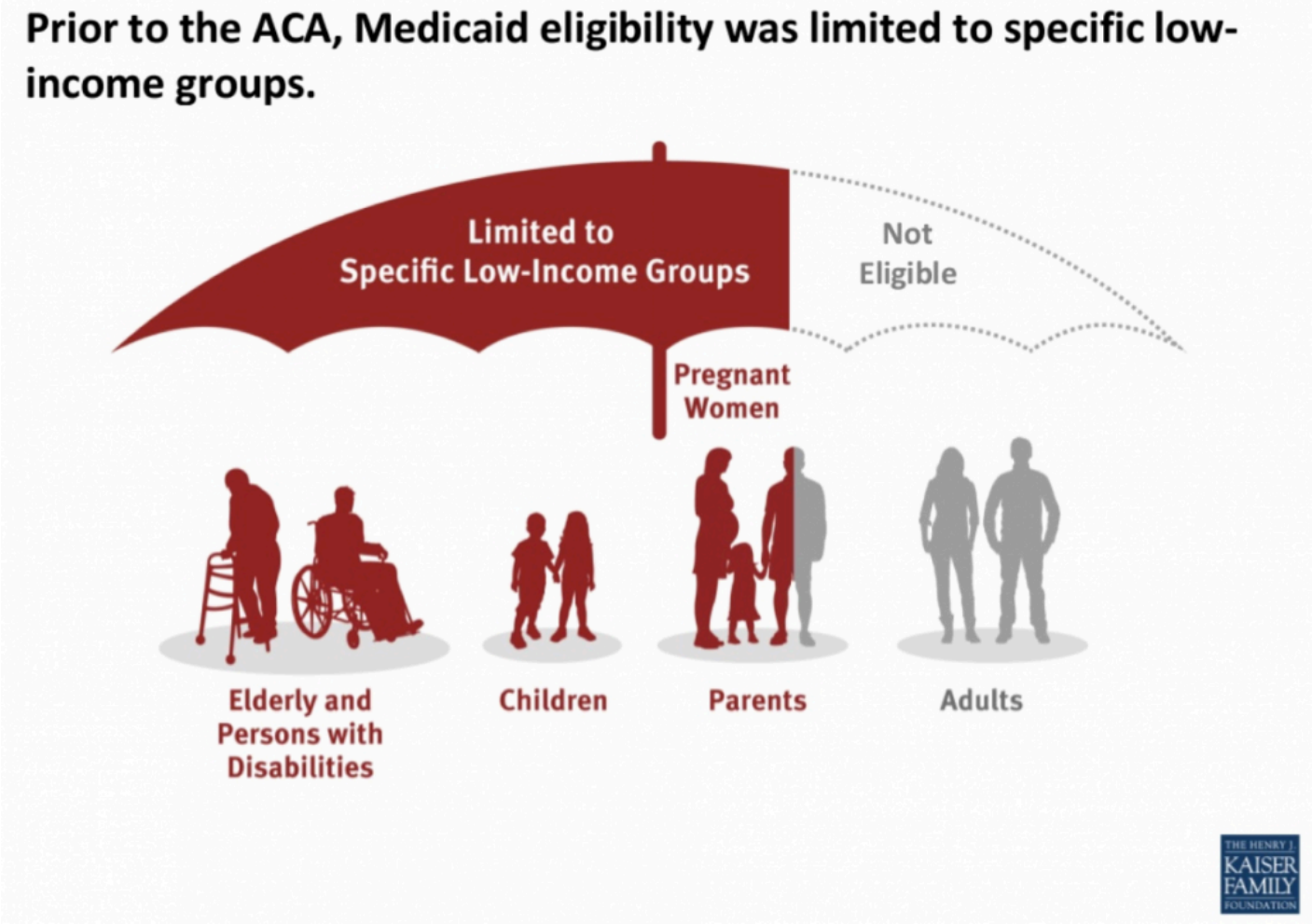


Figure 8.6 Medicaid-Eligible Populations

Individuals with Medicaid plans have support in paying for a variety of health services, including hospital care, laboratory and diagnostic testing, skilled nursing care, home health services, preventative care, and regular outpatient provider visits.

Read more about Medicaid at medicaid.gov.

Other Government Health Funding

There are several other types of health coverage provided by federal and state programs. Read more about these programs in the following box.

Other Federal and State Health Care Funding Programs[6]

- **State Children's Health Insurance Program (CHIP):** A program designed to help provide coverage for uninsured children whose family income is below average but too high to qualify for Medicaid. The federal government provides matching funds to states for health insurance for these families.
  Read more details at InsuredKidsNow.gov.

- **Children and Youth With Special Health Care Needs:** This program coordinates funding and resources to provide care to people with special health needs.
  Read more details at Children With Special Health Care Needs.

- **Tricare:** This program covers about 9 million active duty and retired military personnel and their families.
  Read more details at TRICARE.

- **Veterans Health Administration (VHA):** This government-operated health care system provides comprehensive health services to eligible military veterans. About 9 million veterans are enrolled.
  Read more details at Veterans Health Administration.

6. Schreck, R. I. (2020). *Overview of health care financing.* Merck Manual Consumer Version. https://www.merckmanuals.com/home/fundamentals/financial-issues-in-health-care/overview-of-health-care-financing

- **Indian Health Service:** This system of government hospitals and clinics provides health services to about 2 million Native Americans living on or near a reservation.
  Read more details at Indian Health Service.
- **Federal Employee Health Benefits (FEHB) Program:** This program allows private insurers to offer insurance plans within guidelines set by the government for the benefit of active and retired federal employees and their survivors.
  Read more details at The Federal Employees Health Benefits (FEHB) Program.
- **Refugee Health Promotion Program:** This program provides short-term health insurance to newly arrived refugees.
  Read more details at Refugee Health Promotion Program (RHP).

Private Insurance

Individuals who are not eligible for government-funded health programs like Medicare or Medicaid can purchase private health insurance. Many individuals with private insurance obtain coverage through their employers' benefit packages, where the costs for coverage are shared between the employer and the employee. If an individual does not receive health insurance through their employer, they may purchase it from the Marketplace established by the Affordable Care Act.

- Read more about obtaining health insurance through the ACA Marketplace at healthcare.gov.

Self-Pay

Some individuals do not have health care coverage provided by their employer, do not qualify for Medicare or Medicaid, and do not elect to purchase health insurance coverage. Instead, these individuals go without coverage and pay health care costs as they arise. See Figure 8.7[7] for a graph illustrating the decreasing numbers of uninsured consumers in the United States over the past several decades. Unfortunately, due to the skyrocketing cost of health care services, significant bills can accrue from a single serious illness or traumatic injury that can put consumers without health care coverage in jeopardy of bankruptcy. Nurses can assist uninsured individuals to better understand coverage options by referring them to a case manager or social worker.

7. "Percentage_of_persons_without_health_insurance_in_the_US,_OWID.svg" by Our World In Data is licensed under CC BY 3.0

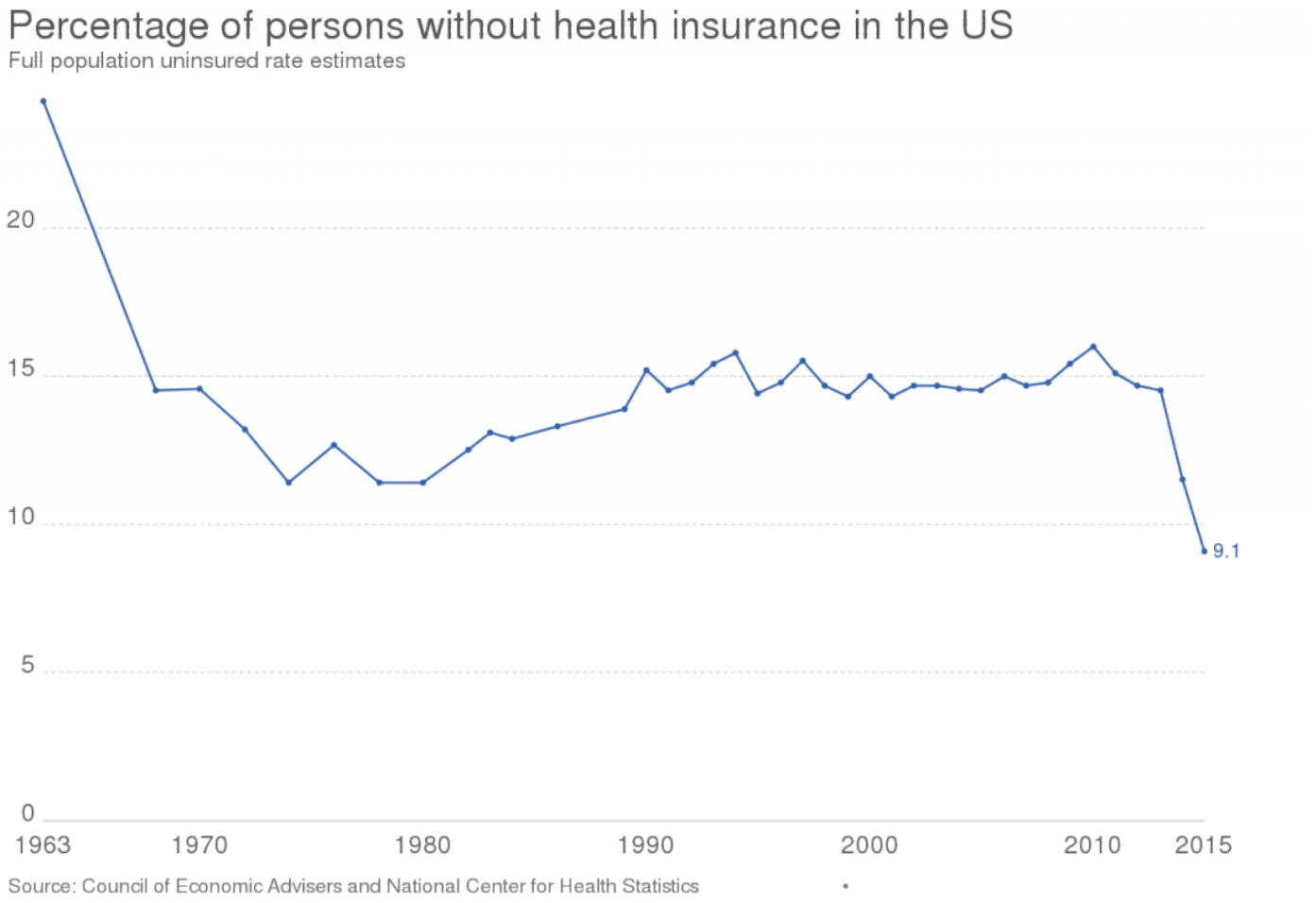


Figure 8.7 Uninsured Individuals

Types of Insurance Coverage

Health insurance plans have different types of coverage. Common types of health insurance plans are HMO, PPO, POS, HDHP, or HSA.

- **Health Maintenance Organization (HMO):** HMO plans usually have the lowest monthly cost for coverage (i.e., premium) but also have a smaller network of providers and hospitals where the consumer may receive insured care. This means the consumer is restricted to receive care only from specific providers and health facilities. Many HMOs also require the consumer to see their primary care provider to request a referral to see a specialist, which may or may not be approved by the HMO. Additionally, many tests, procedures, surgeries, and medications require "preauthorization" by the HMO, which may or may not be approved. Due to these restrictions, consumers may find they sacrifice flexibility and

choice for lower cost of coverage.[8]

- **Preferred Provider Organization (PPO):** PPO plans are typically less restrictive than HMOs. PPOs typically include "in-network" providers and hospitals where costs are lower if care is received in-network, but consumers also have a choice to receive "out-of-network" care at a higher cost. Referrals from a primary care provider are not generally required in a PPO. The monthly premium for a PPO plan is typically higher than an HMO plan, but PPOs allow more consumer flexibility in choosing their health care providers.[9]
- **Point of Service (POS):** POS plans are a combination of HMO and PPO plans, where the insured consumer has a preferred provider network to receive health care services at a lower cost, but also has the flexibility to receive care outside of their network. When consumers venture outside of the network, they often have to pay a significant share of the cost.[10]
- **High Deductible Health Plan (HDHP):** HDHP plans are often popular for younger individuals without chronic health care needs who spend little on health care but require coverage in the event a high-cost injury or illness occurs. HDHPs typically have lower monthly premiums but require the individual to pay more upfront for health care services before the coverage kicks in (referred to as a "deductible"). Individuals with an HDHP often have an associated Health Savings Account (HSA). HDHPs have grown in popularity as more employers offer these plans in an attempt to contain health care costs by shifting more cost-sharing to the consumer.
- **Health Savings Account (HSA):** An HSA is a special account reserved for eligible medical expenses with strict usage rules. Money placed in an HSA

8. Healthcare.gov (2024). How to pick a health insurance plan. https://www.healthcare.gov/choose-a-plan/plan-types/#top

9. Healthcare.gov (2024). How to pick a health insurance plan. https://www.healthcare.gov/choose-a-plan/plan-types/#top

10. Healthcare.gov (2024). How to pick a health insurance plan. https://www.healthcare.gov/choose-a-plan/plan-types/#top

can often be deducted from a consumer's pretaxed pay, resulting in tax savings. In addition to purchasing items like glasses, contacts, and over-the-counter medications, HSAs can often be used to pay for deductibles. Some employers deposit a specified amount of money into an employee's HSA every year to help reimburse high deductibles.

Deductible and Copays

Costs paid by an insured individual are commonly referred to as "out-of-pocket expenses." Out-of-pocket expenses include deductibles and co-pays. A **deductible** is the amount of money a consumer pays before the health care plan pays anything. Deductibles generally apply per person per calendar year. Typically, a PPO has higher premiums but lower deductibles than a HDHP.

A **co-pay** is a flat fee the consumer pays at the time of the health care service. For example, when visiting a primary provider, the consumer may pay $20 to the provider at each visit as a co-pay. Some health care plans require co-pays in addition to deductibles.

Nursing Considerations

Understanding a client's health insurance coverage is important because it may impact their choice of health services and their ability to purchase medications and other supplies. Additionally, if a client is self-pay, it is helpful to refer them to resources such as case managers, social workers, or the financial department of the agency. These resources can assist them in obtaining affordable health care coverage through the ACA Marketplace or other government programs.

8.4 Health Care Reimbursement Models

As discussed in the previous section, hospitals and health care providers are paid for services provided to individuals by government insurance programs (such as Medicare and Medicaid), private insurance companies, or people using their out-of-pocket funds. Traditionally, health care institutions were paid based on a "fee-for-service" model. For example, if a client was admitted to a hospital with pneumonia, the hospital billed that individual's insurance program for the cost of care.

However, as part of a recent national strategy to reduce health care costs, insurance providers have transitioned to "Pay for Performance" reimbursement models that are based on overall agency performance and client outcomes.

Pay for Performance

Pay for Performance, also known as value-based payment, refers to reimbursement models that attach financial incentives to the performance of health care agencies and providers. Pay for Performance models tie higher reimbursement payments to positive client outcomes, best practices, and client satisfaction, thus aligning payment with value and quality.[1] Nurses support higher reimbursement levels to their employers based on their documentation related to nursing care plans and achievement of expected client outcomes.

There are two Pay for Performance models. The first model rewards hospitals and providers with higher reimbursement payments based on how well they perform on process, quality, and efficiency measures. The second model penalizes hospitals and providers for subpar performance by reducing

1. Pay for Performance. (2018). *NEJM catalyst*. https://catalyst.nejm.org/doi/full/10.1056/CAT.18.0245

reimbursement amounts.[2] For example, Medicare no longer reimburses hospitals to treat clients who acquire certain preventable conditions during their hospital stay, such as pressure injuries or urinary tract infections associated with use of catheters.[3]

The Centers for Medicare and Medicaid Services (CMS), spurred by the Affordable Care Act, has led the way in value-based payment with a variety of payment models. CMS is the largest health care funder in the United States with almost 40% of overall health care spending for Medicare and Medicaid. CMS developed three Pay for Performance models that impact hospitals' reimbursement by Medicare. These models are called the Hospital Value-Based Purchasing Program, the Hospital Readmissions Reduction Program, and the Hospital-Acquired Condition Reduction Program. Private insurers are also committed to performance-based payment models. In 2017 *Forbes* reported that almost 50% of insurers' reimbursements were in the form of value-based care models.[4]

HOSPITAL VALUE-BASED PURCHASING PROGRAM

The Hospital Value-Based Purchasing Program (VBP) was designed to improve health care quality and client experience by using financial incentives that encourage hospitals to follow established best clinical practices and improve client satisfaction scores via client satisfaction surveys. Reimbursement is based on hospital performance on measures divided into four quality domains: safety, clinical care, efficiency and cost reduction, and

2. Pay for Performance. (2018). *NEJM catalyst*. https://catalyst.nejm.org/doi/full/10.1056/CAT.18.0245
3. James, J. (2012). *Pay-for-performance*. Health Affairs. https://www.healthaffairs.org/do/10.1377/hpb20121011.90233/full/
4. Pay for Performance. (2018). *NEJM catalyst*. https://catalyst.nejm.org/doi/full/10.1056/CAT.18.0245

client and caregiver-centered experience.[5] The VBP program rewards hospitals based on the quality of care provided to Medicare clients and not just the quantity of services that are provided. Hospitals may have their Medicaid payments reduced by up to 2% if not meeting the quality metrics.

Read more about client satisfaction surveys.

HOSPITAL READMISSIONS REDUCTION PROGRAM

The Hospital Readmissions Reduction Program (HRRP) penalizes hospitals with higher rates of client readmissions compared to other hospitals. HRRP was established by the Affordable Care Act and applies to clients with specific conditions, such as heart attacks, heart failure, pneumonia, chronic obstructive pulmonary disease (COPD), hip or knee replacements, and coronary bypass surgery. Hospitals with poor performance receive a 3% reduction of their Medicare payments. However, it was discovered that hospitals with higher proportions of low-income clients were penalized the most, so Congress passed legislation in 2019 that divided hospitals into groups for comparison based on the socioeconomic status of their client populations.[6]

HOSPITAL-ACQUIRED CONDITION REDUCTION PROGRAM

The Hospital-Acquired Condition Reduction Program (HACRP) was established by the Affordable Care Act. This Pay for Performance model

5. Pay for Performance. (2018). *NEJM catalyst*. https://catalyst.nejm.org/doi/full/10.1056/CAT.18.0245
6. Pay for Performance. (2018). *NEJM catalyst*. https://catalyst.nejm.org/doi/full/10.1056/CAT.18.0245

reduces payments to hospitals based on poor performance regarding client safety and hospital-acquired conditions, such as surgical site infections, hip fractures resulting from falls, and pressure injuries. This model has saved Medicare approximately $350 million per year.[7]

The HACRP model measures the incidence of hospital-acquired conditions, including central line-associated bloodstream infections (CLABSI), catheter-associated urinary tract infections (CAUTI), surgical site infections (SSI), *Methicillin-Resistant Staphylococcus Aureus* (MRSA), and *Clostridium Difficile* (C. diff).[8] As a result, nurses have seen changes in daily practices based on evidence-based practices related to these conditions. For example, stringent documentation is now required for clients with Foley catheters that indicates continued need and associated infection control measures.

OTHER CMS PAY FOR PERFORMANCE MODELS

CMS has created other value-based payment programs for agencies other than hospitals, including the End-Stage Renal Disease (ESRD) Quality Initiative Program, the Skilled Nursing Facility Value-Based Program (SNFVBP), the Home Health Value-Based Program (HHVBP), and the Value Modifier (VM) Program. The VM program is aimed at Medicare Part B providers who receive high, average, or low ratings based on quality and cost measurements as compared to peer agencies.

Impacts of Value-Based Payment

Pay for Performance (i.e., value-based payment) stresses quality over quantity of care and allows health care payers to use reimbursement to encourage

7. Pay for Performance. (2018). *NEJM catalyst*. https://catalyst.nejm.org/doi/full/10.1056/CAT.18.0245
8. Pay for Performance. (2018). *NEJM catalyst*. https://catalyst.nejm.org/doi/full/10.1056/CAT.18.0245

best clinical practices and promote positive health outcomes. It focuses on transparency by using metrics that are publicly reported, thus incentivizing organizations to protect and strengthen their reputations. In this manner, Pay for Performance models encourage accountability and consumer-informed choice.[9] See Figure 8.8[10] for an illustration of Pay for Performance.

9. Pay for Performance. (2018). *NEJM catalyst*. https://catalyst.nejm.org/doi/full/10.1056/CAT.18.0245

10. "Pillars of Pay Performance.png" by Meredith Pomietlo for Chippewa Valley Technical College is licensed under CC BY 4.0

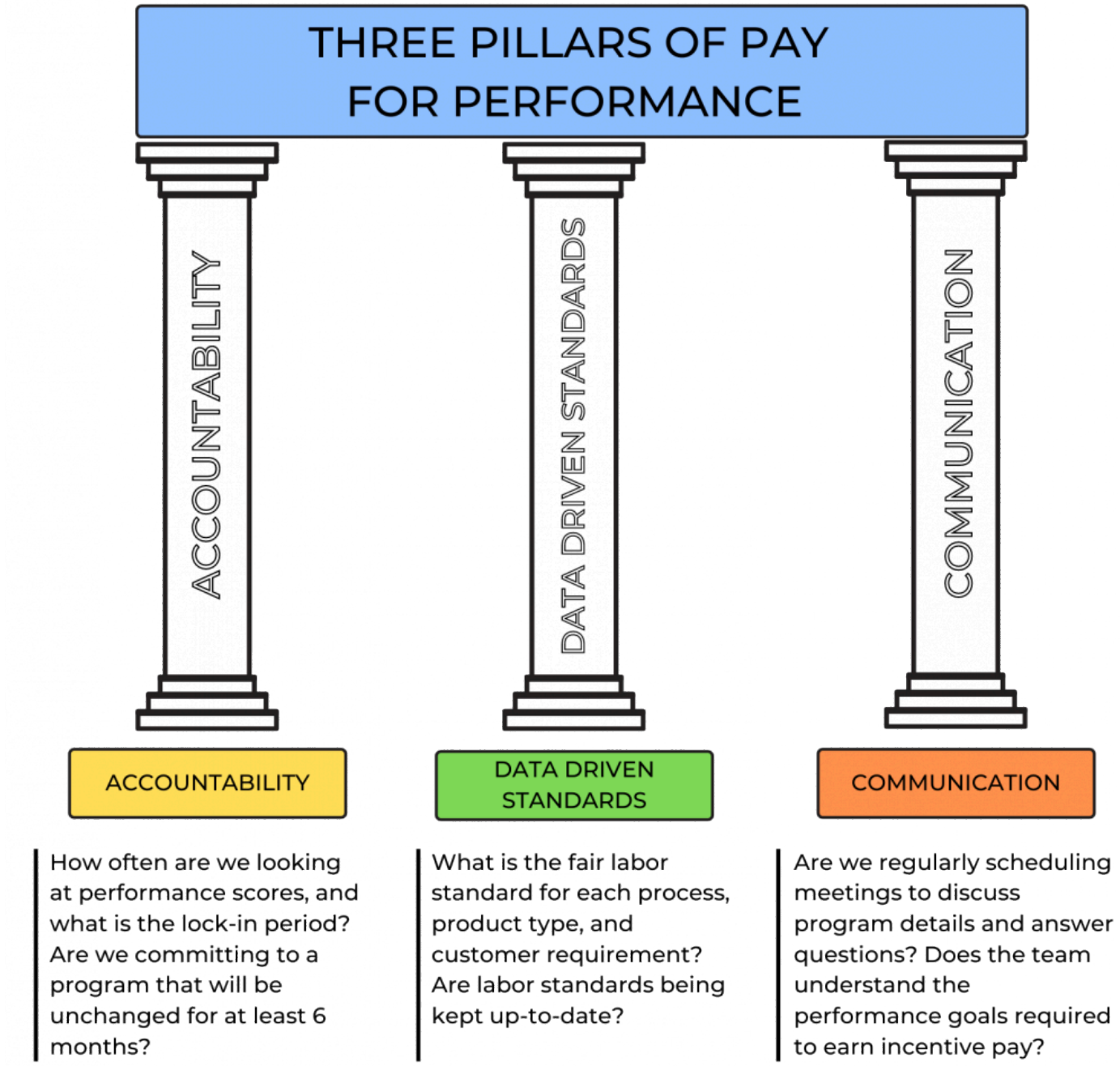


Figure 8.8 Pay for Performance

Pay for Performance models have reduced health care costs and decreased the incidence of poor client outcomes. For example, 30-day hospital

readmission rates have been falling since 2012, indicating HRRP and HACRP are having an impact.[11]

However, there are also disadvantages to value-based payment. As previously discussed, initial research indicated hospitals with higher proportions of low-income clients were being penalized the most, resulting in additional legislation to compare hospital performance in groups based on their clients' socioeconomic status. Nursing leaders continue to emphasize strategies that further address social determinants of health and promote health equity.[12] Read more about equity and social determinants of health in the following subsection.

Nursing Considerations

Nurses have a direct impact on activities related to quality care and reimbursement rates received by their employer. There are several categories of actions nurses can take to improve quality client care, reduce costs, and improve reimbursement. By incorporating these actions into their daily care, nurses can help ensure the funding they need to provide quality client care is received by their employer and resources are allocated appropriately to their clients.

The following categories of actions to improve quality of care are based on the Institute of Medicine (IOM) report *To Err Is Human: Building a Safer Health Care System and Crossing the Quality Chasm*[13]:

11. Pay for Performance. (2018). *NEJM catalyst*. https://catalyst.nejm.org/doi/full/10.1056/CAT.18.0245
12. Pay for Performance. (2018). *NEJM catalyst*. https://catalyst.nejm.org/doi/full/10.1056/CAT.18.0245
13. Avalere Health LLC. (2015). *Optimal nurse staffing to improve quality of care and patient outcomes: Executive summary* [White paper].

- **Effectiveness and Efficiency:** Nurses support their institution's effectiveness and efficiency with individualized nursing care planning, good documentation, and care coordination. With accurate and timely documentation and care coordination, there is reduced care duplication and waste. Coordinating care also helps to reduce the risk of hospital readmissions.
- **Timeliness:** Nurses positively impact timeliness by prioritizing and delegating care. This helps reduce client wait times and delays in care. Read more about these concepts in the "Delegation and Supervision" and "Prioritization" chapters in this book.
- **Safety:** Nurses pay attention to their clients' changing conditions and effectively communicate these changes with appropriate health care team members. They take any concerns about client care up the chain of command until their concerns are resolved.
- **Client-Centered Care:** Nurses support this quality measure by ensuring nursing care plans are individualized for each client. Effective care plans can improve client compliance, resulting in improved client outcomes.
- **Evidence-Based Practice:** Nurses provide care based on evidence-based practice. **Evidence-Based Practice (EBP)** is defined by the American Nurses Association as, "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 client, family, group, community, and population preferences and values."[14] EBP is a component of *Scholarly Inquiry*, one of

https://cdn2.hubspot.net/hubfs/4850206/ANA/NurseStaffingWhitePaper_Final.pdf?__hstc=53609399.b25284991e95c5d4f1c55a49e826489f.1612299494138.1628353446072.1628356381954.16&__hssc=53609399.3.1628356381954&__hsfp=1865500357

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

the ANA's Standards of Professional Practice. Nurses' implementation of EBP ensures proper resources are allocated to the appropriate clients. EBP promotes safe, efficient, and effective health care.[15,16] Read more information about EBP in the "Quality and Evidence-Based Practice" chapter of this book.

- **Equity:** Health care institutions care for all members of their community regardless of client demographics and their associated **social determinants of health (SDOH)**. SDOH are conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes. Health disparities in communities with poor SDOH have been consistently documented in reports by the Agency for Healthcare Research and Quality (AHRQ).[17]

Nurses address negative determinants of health by advocating for interventions that reduce health disparities and promote the delivery of equitable health care resources. The term **health disparities** describes the differences in health outcomes that result from SDOH. Advocating for resources that enhance quality of life can significantly influence a community's health outcomes. Examples of resources that promote health include safe and affordable housing, access to education, public safety,

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

16. Stevens, K. (2013). The impact of evidence-based practice in nursing and the next big ideas. *OJIN: The Online Journal of Issues in Nursing, 18*(2). https://ojin.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Vol-18-2013/No2-May-2013/Impact-of-Evidence-Based-Practice.html

17. Centers for Disease Control and Prevention. (2020). *Social determinants of health: Know what affects health*. https://www.cdc.gov/socialdeterminants/index.htm

availability of healthy foods, local emergency/health services, and environments free of life-threatening toxins.

A related term is **health care disparity** that refers to differences in access to health care and insurance coverage. Health disparities and health care disparities can lead to decreased quality of life, increased personal costs, and lower life expectancy. More broadly, these disparities also translate to greater societal costs, such as the financial burden of uncontrolled chronic illnesses. An example of nurses addressing health care disparities are nurse practitioners providing health care according to their scope of practice to underserved populations in rural communities.

The ANA promotes nurse advocacy in workplaces and local communities. There are many ways nurses can promote health and wellness within their communities through a variety of advocacy programs at the federal, state, and community level.[18] Read more information in the "Advocacy" chapter of this book and additional information about advocacy and reducing health disparities in the following boxes.

- Read more about ANA Policy and Advocacy.

- Read more about addressing health disparities in the "Diverse Patients" chapter in Open RN *Nursing Fundamentals, 2e*.

18. Agency for Healthcare Research and Quality. (2021). *2019 national healthcare quality and disparities report*. https://www.ahrq.gov/research/findings/nhqrdr/nhqdr19/index.html

8.5 Budgets and Staffing

Economics and health care reimbursement models impact health care institutional budgets that ultimately impact nurse staffing. A **budget** is an estimate of revenue and expenses over a specified period of time, usually over a year. There are two basic types of health care budgets that affect nursing: capital and operating budgets. **Capital budgets** are 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. **Operating budgets** include personnel costs and annual facility operating costs.[1] Typically 40% of the operating budgets of health care agencies are dedicated to nursing staffing. As a result, nursing is often targeted for reduced hours and other cutbacks.[2]

What is the value of a nurse? Nurses are priceless to the clients, families, and communities they serve, but health care organizations are tasked with calculating the cost of delivering safe, high-quality nursing care using affordable staffing models. All members of the health care team must understand the relationship between economics, resources, budgeting, and staffing, and how these issues affect their ability to provide safe, quality care to their clients.

As health care agencies continue to adapt to meet "Pay for Performance" reimbursement models and deliver cost-effective care to an aging population with complex health needs, many nurses are experiencing changes in staffing models.[3] Strategies implemented by agencies to facilitate cost-

1. American Nurses Association. (n.d.). *Advocacy*. https://www.nursingworld.org/practice-policy/advocacy/
2. Kenton, W. (2024). *Capital budgeting*. Investopedia. https://www.investopedia.com/terms/c/capitalbudgeting.asp
3. American Nurses Association. (n.d.). *Advocacy*. https://www.nursingworld.org/practice-policy/nurse-staffing/

effective nurse staffing include acuity-based staffing, team nursing, mandatory overtime, floating, on call, and off with benefits. Agencies may also use agency nurses when nurse shortages occur.

Acuity-Based Staffing

Historically, inpatient staffing patterns focused on "nurse-to-client ratios" where a specific number of clients were assigned to each registered nurse during a shift. **Acuity-based staffing** is a client assignment model that takes into account the level of client care required based on the severity of a client's illness or condition. As a result of acuity-based staffing, the number of clients a nurse cares for often varies from shift to shift as the needs of the clients change. Acuity-based staffing promotes efficient use of resources by ensuring nurses have adequate time to care for complex clients. Read more information about acuity-based staffing in the "Prioritization" chapter.

Team Nursing

Team nursing is a common staffing pattern that uses a combination of Registered Nurses (RNs), Licensed Practical/Vocational Nurses (LPN/VNs), and Unlicensed Assistive Personnel (UAP) to care for a group of clients. The RN is the leader of a nursing team, making assignments and delegating nursing care to other members of the team with appropriate supervision. Team nursing is an example of allocating human resources wisely to provide quality and cost-effective care. In order for team nursing to be successful, team members must use effective communication and organize their shift as a team. Read more about team nursing in the "Delegation and Supervision" chapter of this book.

Mandatory Overtime

When client numbers and acuity levels exceed the number of staff scheduled for a shift, nurses may experience mandatory overtime as an agency staffing tool. **Mandatory overtime** requires a nurse to stay and care for clients beyond their scheduled shift when there is a lack of nursing staff (often referred to as short staffing). The American Nurses Association recognizes mandatory

overtime as a dangerous staffing practice because of client safety concerns related to overtired staff. Depending on state laws, nurses can be held liable for client abandonment or neglect charges for refusing to stay when mandated. Nurses should be aware of state and organizational policies related to mandatory overtime.[4]

> Read more about ANA's advocacy for adequate nurse staffing.

Floating

Floating is a common agency staffing strategy that asks nurses to temporarily work on a different unit to help cover a short-staffed shift. Floating can reduce personnel costs by reducing overtime payments for staff. It can also reduce nurse burnout occurring from working in an environment without enough personnel.

Nurses must be aware of their rights and responsibilities when asked to float because they are still held accountable for providing safe client care according to their state's Nurse Practice Act and professional standards of care. Before accepting a floating assignment, nurses should ensure the assignment is aligned with their skill set and they receive orientation to the new environment before caring for clients. If an error occurs and the nurse is held liable, the fact they received a floating assignment does not justify the error. As the ANA states, nurses don't just have the right to refuse a floating client assignment; they have the obligation to do so if it is unsafe.[5] The ANA has developed several questions to guide nurses through the decision

4. American Nurses Association. (n.d.). *Nurse staffing*. https://www.nursingworld.org/practice-policy/nurse-staffing/#staffinfo

5. American Nurses Association. (n.d.) *Top issues for staff nurses*. https://www.nursingworld.org/practice-policy/nurse-staffing/

process of accepting client assignments. Review these questions in the following box.

ANA's Suggested Questions When Deciding on Accepting a Client Assignment[6]

- What is the assignment? Clarify what is expected; do not assume. Be certain about the details.
- What are the characteristics of the clients being assigned? Don't just respond to the number of clients assigned. Make a critical assessment of the needs of each client and their complexity and stability. Be aware of the resources available to meet those needs.
- Do you have the expertise to care for the clients? Always ask yourself if you are familiar with caring for the types of clients assigned? If this is a "float assignment," are you cross-trained to care for these clients? Is there a "buddy system" in place with staff who are familiar with the unit? If there is no cross-training or "buddy system," has the client load been modified accordingly?
- Do you have the experience and knowledge to manage the clients for whom you are being assigned care? If the answer to the question is "No," you have an obligation to articulate your limitations. Limitations in experience and knowledge may not require refusal of the assignment, but rather an agreement regarding supervision or a modification of the assignment to ensure client safety. If no

6. American Nurses Association. *Top issues for staff nurses.* https://www.nursingworld.org/practice-policy/nurse-staffing/

accommodation for limitations is considered, the nurse has an obligation to refuse an assignment for which they lack education or experience.

- What is the geography of the assignment? Are you being asked to care for clients who are in close proximity for efficient management, or are the clients at opposite ends of the hall or in different units? If there are geographic difficulties, what resources are available to manage the situation? If the clients are in more than one unit and you must go to another unit to provide care, who will monitor clients out of your immediate attention?
- Is this a temporary assignment? When other staff are located for assistance, will you be relieved? If the assignment is temporary, it may be possible to accept a difficult assignment knowing that there will soon be reinforcements. Is there a pattern of short staffing at this agency, or is this truly an emergency?
- Is this a crisis or an ongoing staffing pattern? If the assignment is being made because of an immediate need or crisis in the unit, the decision to accept the assignment may be based on that immediate need. However, if the staffing pattern is an ongoing problem, you have the obligation to identify unmet standards of care that are occurring as a result of ongoing staffing inadequacies. This may result in a formal request for peer review using the appropriate channels.
- Can you take the assignment in good faith? If not, you will need to have the assignment modified or refuse the assignment. Consult your state's Nurse Practice Act regarding clarification of accepting an assignment in good faith.

On Call and Off With Benefits

When staffing projected for a shift exceeds the number of clients admitted and their acuity, agencies often decrease staffing due to operating budget limitations. Two common approaches that agencies use to reduce staffing on a shift-to-shift basis are placing nurses “on call” or “off with benefits.”

On Call

On call is an agency staffing strategy when a nurse is not immediately needed for their scheduled shift. The nurse may have the options to report to work and do work-related education or stay home. When a nurse is on call, they typically receive a reduced hourly wage and have a required response time. A required response time means if a nurse who is on call is needed later in the shift, they need to be able to report and assume client care in a designated amount of time.

Off With Benefits

A nurse may be placed “**off with benefits**” when not needed for their scheduled shift. When a nurse is placed off with benefits, they typically do not receive an hourly wage and are not expected to report to work or be on call, but still accrue benefits such as insurance and paid time off.

Agency Nursing

Agency nursing is an industry in health care that provides nurses to hospitals and health care facilities in need of staff. Nurse agencies employ nurses to work on an as-needed basis and place them in facilities that have staffing shortages.

Advocacy by the ANA for Appropriate Nurse Staffing

According to the ANA, there is significant evidence showing appropriate nurse staffing contributes to improved client outcomes and greater

satisfaction for both clients and staff. Appropriate staffing levels have multiple client benefits, including the following[7]:

- Reduced mortality rates
- Reduced length of client stays
- Reduced number of preventable events, such as falls and infections

Nurses also benefit from appropriate staffing. Appropriate workload allows nurses to utilize their full expertise, without the pressure of fatigue. A recent report suggested that staff levels should depend on the following factors[8]:

- Client complexity, acuity, or stability
- Number of admissions, discharges, and transfers
- Professional nurses' and other staff members' skill level and expertise
- Physical space and layout of the nursing unit
- Availability of technical support and other resources

Read more information about client acuity tools in the "Prioritization" chapter.

> Visit ANA's interactive Principles of Nurse Staffing infographic.

7. American Nurses Association. (n.d). *Nurse staffing*. https://www.nursingworld.org/practice-policy/nurse-staffing/

8. American Nurses Association. (n.d.). *Questions to ask in making the decision to accept a staffing assignment for nursing*. https://www.nursingworld.org/practice-policy/nurse-staffing/questions-to-ask-in-making-the-decision-to-accept-a-staffing-assignment-for-nurses/

Cost-Effective Nursing Care

One of ANA's Standards of Professional Performance is *Resource Stewardship*. The *Resource Stewardship* standard states, "The registered nurse utilizes appropriate resources to plan, provide, and sustain evidence-based nursing services that are safe, effective, financially responsible, and used judiciously."[9] Nurses have a fiscal responsibility to demonstrate resource stewardship to the employing organization and payer of care. This responsibility extends beyond direct client care and encompasses a broader role in health care sustainability. By effectively managing resources, nurses help reduce unnecessary expenditures and ensure that funds are allocated where they are most needed. This can include everything from minimizing waste in the use of medical supplies to optimizing staffing levels to avoid both overworking and underutilizing nursing staff.

Nurses can help contain health care costs by advocating for clients and ensuring their care is received on time, the plan of care is appropriate and individualized to them, and clear documentation has been completed. These steps reduce waste, avoid repeated tests, and ensure timely treatments that promote positive client outcomes and reduce unnecessary spending. Nurses routinely incorporate these practices to provide cost-effective nursing care in their daily practice:

- Keeping supplies near the client's room
- Preventing waste by only bringing needed supplies into a client's room
- Avoiding prepackaged kits with unnecessary supplies
- Avoiding "Admission Bags" with unnecessary supplies
- Using financially-sound thinking
    - Understanding health care costs and reimbursement models
    - Charging out supplies and equipment according to agency policy
- Being Productive

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

- Organizing and prioritizing
- Using effective time management
- Grouping tasks when entering client rooms (i.e., clustering cares)
- Assigning and delegating nursing care to the nursing team according to the state Nurse Practice Act and agency policy
- Using effective team communication to avoid duplication of tasks and request assistance when needed
- Updating and individualizing clients' nursing care plans according to their current needs
- Documenting for continuity of client care that avoids duplication and focuses on effective interventions based on identified outcomes and goals

Resource Stewardship

Resource Stewardship is one of the Standards of Professional Performance established by the American Nursing Association (ANA). **Resource stewardship** is defined as using appropriate resources to plan, provide, and sustain evidence-based nursing services that are safe, effective, financially responsible, and used judiciously. See the following box for competencies associated with the ANA's *Resource Stewardship* Standard of Professional Performance.[1]

Competencies of ANA's Resource Stewardship Standard of Professional Performance[2]

- Partners with the health care consumer and other stakeholders to identify care needs and necessary resources to achieve desired outcomes.
- Collaborates with the health care consumer and other stakeholders to assess costs, availability, risks, and benefits in decisions about care.
- Secures appropriate resources to address needs across the health care continuum.
- Advocates for equitable resources that support and enhance nursing practice and health outcomes.

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

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

- Integrates connected health technologies into practice to promote positive interactions between health care consumers and care providers.
- Uses organizational and community resources to implement interprofessional plans.
- Addresses discriminatory health care practices and the adverse impact on allocation of resources.

Case Management

Nurses are tasked with daily case management activities and allocating appropriate resources to their clients. Two common types of case management that staff nurses provide are educating clients about using appropriate levels of care and encouraging the use of cost-effective health care team members.

Several levels of care are available to clients for their health care services:

- **Emergency department care** has specialized providers and high-level diagnostics and should be reserved for immediate and potentially life-threatening needs.
- **Urgent care** is an elevated level of care above an outpatient visit, yet below the needs of an emergency visit. Nurses should refer clients to this setting if they have a health need that needs attention within the next 24 hours but is not life-threatening.
- **Outpatient health settings** provide health maintenance for chronic disease or treatment of nonurgent acute conditions. They also provide preventative services like well-baby checks and immunizations. In the outpatient setting, the nurse recognizes the client's time with a provider is limited, so the majority of a nurse's time is often spent providing client education, answering questions, and coordinating care.
- **Inpatient and acute care** typically occurs in a hospital setting where

skilled nursing, diagnostic tests, and medical treatments are required. Nursing goals in these settings are to address immediate health concerns, stabilize the client, and prepare them for discharge. Most inpatient stays are 72 hours or less, so nurses must provide efficient care that includes adequate client education regarding follow-up care after discharge.

- **Assisted living** refers to licensed facilities that provide safe living accommodations and three meals daily. Residents receive assistance with medications and ADLs and may receive general nursing care.[3]
- **Skilled nursing facilities**, commonly referred to as "nursing homes" or "long-term care facilities," are licensed facilities that provide 24-hour licensed nursing services. Residents may require total assistance with ADLs.[4]
- **Home health** refers to services provided in a client's home that may include nursing, home health aide, physical therapy (PT), occupational therapy (OT), and speech therapy.[5]
- **Hospice** offers palliative and supportive services providing physical, psychological, social, and spiritual care for dying clients and their families. Services may be provided in the client's home or an inpatient setting. Hospice may include nursing, home health aide, social worker, chaplain, PT, OT, ST, nutritional therapy, and volunteer services.[6]
- **Telehealth** is a fairly new and expanding health delivery model. Telehealth

3. Utah Department of Health. (n.d.). *Levels of care*. https://health.utah.gov/hflcra/facinfo/HFLevelsOfCare.PDF

4. Utah Department of Health. (n.d.). *Levels of care*. https://health.utah.gov/hflcra/facinfo/HFLevelsOfCare.PDF

5. Utah Department of Health. (n.d.). *Levels of care*. https://health.utah.gov/hflcra/facinfo/HFLevelsOfCare.PDF

6. Utah Department of Health. (n.d.). *Levels of care*. https://health.utah.gov/hflcra/facinfo/HFLevelsOfCare.PDF

> is a form of an outpatient health service where the client and member of the health care team are able to connect remotely using telephone calls or video conferencing on a computer with an Internet connection. Devices may be provided to monitor vital signs and other health indicators. Telehealth enhances client access to multiple providers without the burden of travel. Telehealth has become an important resource in rural communities, especially due to social distancing required by the COVID-19 pandemic.[7]

Nurses can also address the economic pressures within the health care system by utilizing and advocating for cost-effective care by providers on the health care team. In this manner, limited health care resources are allocated wisely, and consumers receive the health care they need. For example, many nurse practitioners (NPs) and physician assistants (PAs) function as primary providers in outpatient settings and provide preventative services, treat self-limited acute medical conditions, and manage chronic disease. NPs and PAs are trained to refer clients for specialized care when indicated. Some NPs and PAs work in specialized inpatient areas and serve as the primary point of contact during a client's hospital stay. Nurses recognize the time of specialty physicians is limited and unnecessary referrals can be costly to the client. By using and advocating for the wise use of these health care human resources, nurses can help reduce the overall cost of health care.

7. Health Resources & Services Administration. (2024). *What is telehealth?* https://telehealth.hhs.gov/patients/understanding-telehealth/

8.7 Spotlight Application

Emma is assigned to care for a 64-year-old client readmitted with heart failure (HF). Emma recognizes the client's name during shift report as the reporting nurse comments how this client was a "frequent flyer," and he was just discharged last week. The reporting nurse spends little time describing the client's actual condition and focuses comments on how the client "might as well put his name plaque on the door" because he is here so frequently. Emma does agree that the client has been readmitted very frequently with HF exacerbations but is concerned by the dismissive comments by her peer. She is determined to spend time with this client on this admission and find out more about his home environment, support system, and self-care.

Reflective Questions

- How do the frequent readmissions affect the client's health care costs and the hospital's reimbursement levels by Medicare and private insurance companies?
- What additional nursing interventions might help prevent future frequent readmissions and reduce costs?

Emma engages in a conversation with the client about his dietary habits at home. He reports that his wife passed away one year ago from breast cancer, and he has been preparing his own meals since that time by using easy-to-prepare and cheap foods. Canned soups, boxed meals, and chips are common staples in his diet. Through Emma's conversation with the client, she can see that the client needs dietary instruction and further education about monitoring his fluid retention with daily weights. He seems engaged in exploring different food preparations and was unaware that foods could exacerbate his heart failure. When Emma asked if he had been taught about this on previous admissions, he stated that no one took the time to talk with him about his home situation. He reports that he received pamphlets but never really took the time to read them because the print was so small. Emma reflects on how preventative education opportunities

were missed and increased costs were incurred by the client and the health care organization as a result.

8.8 Learning Activities

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nursingmpc/?p=293#h5p-11

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nursingmpc/?p=293#h5p-12

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nursingmpc/?p=293#h5p-13

Test your knowledge using this NCLEX Next Generation-style Case Study. You may reset

- and resubmit your answers to this question an unlimited number of times.[1]

1. “Chapter 8, Assignment 1” by Travis Christman for OpenRN is licensed under CC BY-NC 4.0

VIII Glossary

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

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.

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.

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.

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.

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 client, family, group, community, and population preferences and values.

Extrinsic factors: External elements that impact health care costs.

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

Health care disparity: Differences in access to health care and insurance coverage.

Health disparities: Differences in health outcomes that result from social determinants of health (SDOH).

Intrinsic factors: Factors that are inherent to the characteristics and needs of the population.

Mandatory overtime: A requirement by agencies for nurses to stay and care for clients 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.

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.

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.

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

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.

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

PART IX

CHAPTER 9 - QUALITY AND EVIDENCE-BASED PRACTICE

9.1 Quality and Evidence-Based Practice Introduction

Learning Objectives

- Examine the role of utilization review and continuous quality improvement
- Describe the role of research in providing evidence-based, quality client care
- Identify the accreditation process for agencies
- Explain quality client care based on standards of nursing practice
- Examine the role of government, nursing, and other organizations in developing standards for quality nursing practice
- Explain how informatics systems promote quality and safety in health care delivery
- Examine the role of the nurse in workplace quality improvement processes

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 client outcomes to support the value of a nurse. See an example of one of Florence Nightingale's diagrams comparing the causes of mortality in the Army in Figure 9.1.[1] Over the years nursing theorists and governing agencies have continued the evaluation work of Florence Nightingale by collecting

1. "Nightingale-mortality.jpg" by Florence Nightingale is licensed under Public Domain

data, using statistics, and creating reports to ensure the best quality care is being delivered to all clients.

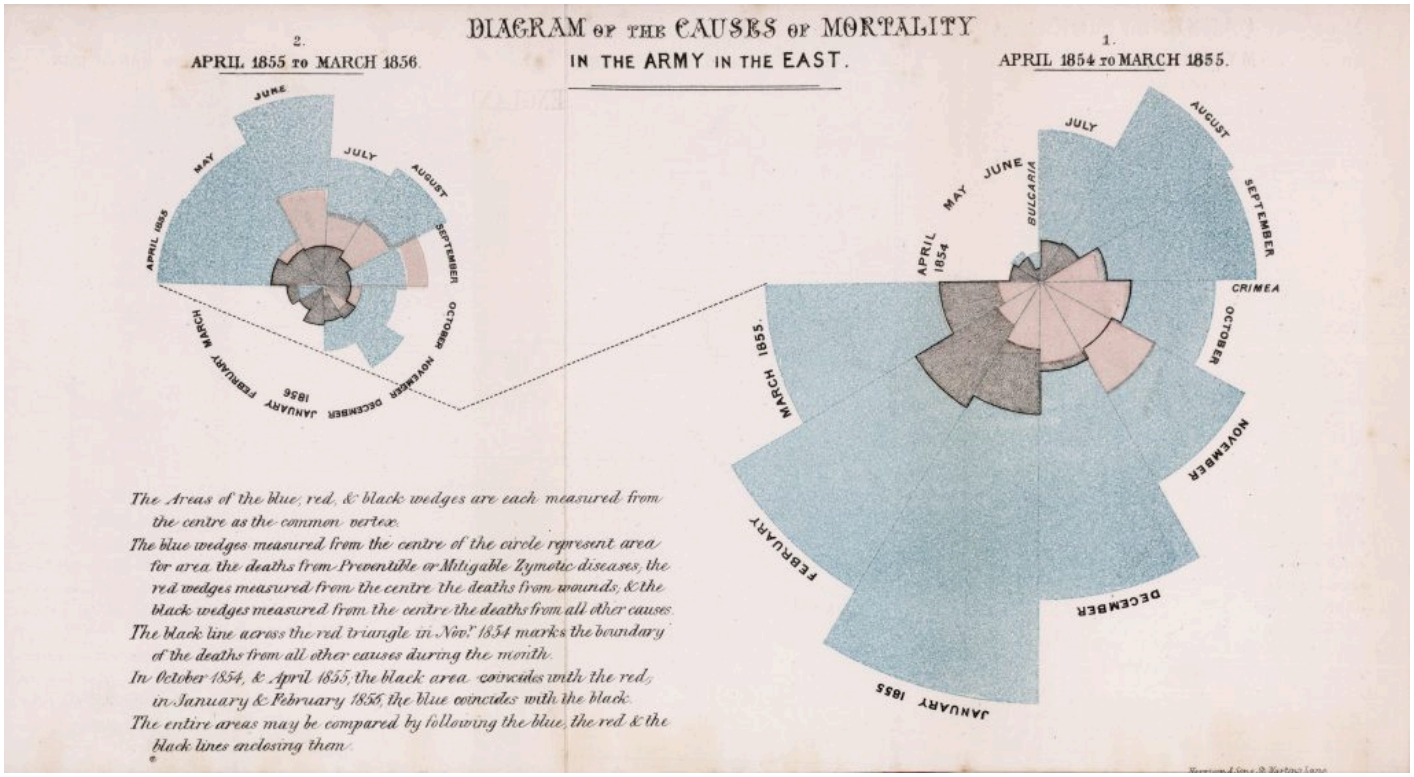


Figure 9.1 Florence Nightingale's Diagram of the Causes of Mortality

In previous chapters we discussed how delegation, prioritization, and working as part of an interdisciplinary team all contribute to the delivery of effective and high-quality care. However, 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.

9.2 Quality Care

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

ANA 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."[1] 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.[2] 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.[3]

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

2. Stevens, K. R. (2013). The impact of evidence-based practice in nursing and the next big ideas. *OJIN: The Online Journal of Issues in Nursing, 18*(2), manuscript 4. https://ojin.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Vol-18-2013/No2-May-2013/Impact-of-Evidence-Based-Practice.html

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

Competencies of ANA's Quality of Practice Standard of Professional Performance[4]

- 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.

Reflective Questions

1. What *Quality of Practice* competencies have you already demonstrated during your nursing education?

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

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)?

This chapter will review content related to the competencies of the ANA's *Quality of Practice* Standard of Professional Performance. Additional information about peer review is discussed in the "Leadership and Management" chapter, and specialty certification is discussed in the "Preparation for the RN Role" chapter.

Quality and Safety Education for Nurses

The Quality and Safety Education for Nurses (QSEN) project advocates for safe, quality client care by defining six competencies for prelicensure nursing students: Patient-Centered Care, Teamwork and Collaboration, Evidence-Based Practice, Quality Improvement, Safety, and Informatics. These competencies are further discussed in the "Advocacy" chapter.

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[5,6]:

- **Safe:** Avoiding harm to clients 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).
- **Client-centered:** Providing care that is respectful of and responsive to individual client preferences, needs, and values and ensuring that client 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 client 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

5. Agency for Healthcare Research & Quality. (2022). *Six domains of health care quality.* https://www.ahrq.gov/talkingquality/measures/six-domains.html
6. Institute of Medicine (US) Committee on Quality of Health Care in America. (2001). *Crossing the quality chasm: A new health system for the 21st century.* National Academies Press. https://pubmed.ncbi.nlm.nih.gov/25057539/

promotes nursing as a leader in catalyzing adoption of EBP and using it as a marker of excellence.[7]

Magnet Recognition Program

The Magnet Recognition Program is an award from the American Nurses Credentialing Center (ANCC) that recognizes organizational commitment to nursing excellence. The award recognizes organizations worldwide where nursing leaders have successfully aligned their nursing strategic goals to improve the organization's client outcomes. To nurses, Magnet Recognition means education and development are available through every stage of their career. To clients, it means quality care is delivered by nurses who are supported to be the best that they can be.[8] See Figure 9.2[9] for an image related to the Magnet Recognition Program.

7. Stevens, K. R. (2013). The impact of evidence-based practice in nursing and the next big ideas. *OJIN: The Online Journal of Issues in Nursing, 18*(2), manuscript 4. https://ojin.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Vol-18-2013/No2-May-2013/Impact-of-Evidence-Based-Practice.html

8. American Nurses Credentialing Center. (2024). *ANCC magnet recognition program*. https://www.nursingworld.org/organizational-programs/magnet/

9. "Magnet_Recognition_Logo_CMYK_-png-.png" by Mattmitchell37 is licensed under CC BY-SA 4.0



Figure 9.2 Magnet Recognition

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. As discussed in the "Health Care Reimbursement Models" section of the "Health Care Economics" chapter, value-based payment reimbursement models use financial incentives to reward quality health care and positive client outcomes. For example, Medicare no longer reimburses hospitals to treat clients who acquire certain preventable conditions during their hospital stay, such as pressure injuries or urinary tract infections associated with use of catheters.[10] 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

10. James, J. (2012). *Pay-for-performance*. Health Affairs. https://www.healthaffairs.org/do/10.1377/hpb20121011.90233/full/

the care an organization delivers, as well as clients' responses to the care provided. These quality measures evaluate many areas of health care, including the following:[11]

- Health outcomes
- Clinical processes
- Client safety
- Efficient use of health care resources
- Care coordination
- Client engagement in their own care
- Client perceptions of their care

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

> Visit the CMS *What is a Quality Measure* web page.

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

11. CMS.gov. (2024). *Quality measures*. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures

- 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 client safety goals. Please see Table 9.2 for more information on accrediting organizations.

Table 9.2. Accrediting Organizations [12, 13, 14 15]

12. Joint Commission International. (2024). *Who we are*. https://www.jointcommission.org/?utm_campaign=tjc_brand__1_core&utm_source=google&utm_medium=cpc&gad_source=1&gclid=CjwKCAjwnK60BhA9EiwAmpHZw55yd91qdT0f3Q6nauq82Oo3uHe5nPJKBwT81CxvmdtkGrjdc26GchoCvz8QAvD_BwE

13. NCQA. (2024). *About NCQA*. https://www.ncqa.org/about-ncqa/

14. AMA Ed Hub. (2024). *About the AMA's CME accreditation*. https://edhub.ama-assn.org/pages/ama-cme

15. ACHC. (2024). *About accreditation*. https://www.achc.org/

Organization	Overview	History	Accreditation Process	Standards	Impact
The Joint Commission	Non-profit organization accrediting and certifying health care organizations and programs in the U.S.	Founded in 1951, aims to improve public health care quality and safety	Conducts rigorous on-site surveys to assess compliance with standards covering client care, medication safety, infection control, and overall performance	Developed with input from health care professionals, providers, and consumers and designed to help measure, assess, and improve performance	Recognized a symbol of quality, reflecting commitmer to high performanc standards
National Committee for Quality Assurance (NCQA)	Private, non-profit organization improving health care quality through evidence-based standards, measures, programs, and accreditation	Established in 1990, provides quality information for health care decision-making	Comprehensive review of policies and procedures, including quality management, utilization management, credentialing, and member rights	Widely regarded standards used by CMS and state governments for quality oversight	Demonstrat commitmer to improvin health care quality and adhering to high performanc standards
American Medical Accreditation Program (AMAP)	Program by AMA aimed at improving medical care quality by setting high standards for physicians	Launched in the late 1990s, assesses physicians' qualifications and ethical standards	Detailed review process, including verification of credentials, practice history assessment, and compliance with CME requirements	Ensures physicians provide high-quality care, maintain competency, and adhere to ethical practices	Recognizes physicians' commitmer to high-qual care and medical practice standards
American Accreditation Healthcare Commission (AAHC) / URAC	Independent, non-profit organization promoting health care quality through accreditation, certification, and measurement	Founded in 1990, expanded from utilization review to a wide range of health care services	Thorough review of policies, procedures, and performance, including on-site visits and compliance assessment	Developed by a broad array of stakeholders to promote evidence-based practices, client safety, and continuous improvement	Recognized a mark of excellence, demonstrati commitmer to quality an accountabili

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 client 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.[16]

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.[17]

> Read more about the National Hospital Inpatient Quality Measures.

16. John Hopkins Medicine. (n.d.). *Core measures*. https://www.hopkinsmedicine.org/patient_safety/core_measures.html

17. The Joint Commission. (n.d.). *Measures*. https://www.jointcommission.org/en/measurement/measures/

National 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 client 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[18]:

- 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.

> Read the current agency-specific National Patient Safety Goals.

18. The Joint Commission. (2025). *2025 national patient safety goals.* https://www.jointcommission.org/standards/national-patient-safety-goals/

9.3 Measuring and Improving Quality

Now that we have discussed the various ways that quality health care is defined, let's discuss how quality care is measured, evaluated, and improved.

Utilization Review

Thinking back to value-based reimbursement models discussed in the "Health Care Economics" chapter, recall how 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 clients' needs. Information from clients' medical records is analyzed, along with client demographics, to evaluate resource allocation, efficiency, and quality of health promotion initiatives.[1] See Figure 9.3[2] for an illustration of utilization review related to costs.

1. Institute of Medicine (US) Committee on Utilization Management by Third Parties, Gray, B. H., & Field, M. J., (Eds.). (1989). *Controlling costs and changing patient care? The role of utilization management*. National Academies Press. https://www.ncbi.nlm.nih.gov/books/NBK235000

2. "Analyzing_Financial_Data_(5099605109).jpg" by Dave Dugdale is licensed under CC BY-SA 2.0



Figure 9.3 Utilization Review

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.[3] 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.[4] It is a nursing specialty with certification available from the ANCC. See Figure 9.4[5] for an artistic rendition of informatics.

3. QSEN Institute. (n.d.). *QSEN competencies: Quality improvement (QI)*. https://qsen.org/competencies/pre-licensure-ksas/#quality_improvement
4. AMIA. (n.d.). *Informatics: Research and practice*. https://amia.org/about-amia/why-informatics/informatics-research-and-practice
5. "informatics-1322241_1920.jpg" by mariojsantos at Pixabay.com is licensed under CC0



Figure 9.4 Informatics

These are several benefits of using informatics in health care[6]:

- **Improvement of Client Safety:** Informatics allows for up-to-date information sharing by both the client and members of the health care team. Using informatics can help to reduce the occurrence of medication errors, as well as monitor client side effects and overall health status. For example, barcode scanning has reduced medication errors by ensuring the correct dose is administered to the correct client at the correct time.
- **Reduction of Delays in Care:** Some health care informatics systems allow for direct communication between health care team members and clients. 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.

6. Otokiti, A. (2019). Using informatics to improve healthcare quality. *International Journal of Health Care Qual Assurance, 32*(2), 425-430. https://doi.org/10.1108/ijhcqa-03-2018-0062

- **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, clients can request their records be shared with health providers from other health organizations, which reduces duplication and unnecessary spending across the nation.
- **Promotion of Client-Centered Care:** Many informatics systems have "portal" options where the client and/or designated personnel are able to be active participants in the care planning and health promotion processes. Informatics offers an inclusive environment for clients 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[7]:

- Nursing Care Hours Per Patient Day
- Hospital-Acquired Pressure Injuries

7. Montalvo, I. (2007). The National Database of Nursing Quality Indicators (NDNQI). *The Online Journal of Issues in Nursing, 12*(3). https://ojin.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Volume122007/No3Sept07/NursingQualityIndicators.html

- RN Job Satisfaction

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

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

Quality Improvement

Quality Improvement (QI) is a systematic process using measurable data to improve health care services and the overall health status of clients.[8] 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."[9]

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?

8. Study.com. (n.d.). *What is economics? – Definition, history, timeline & importance* [Video]. https://study.com/academy/lesson/what-is-economics-definition-history-timeline-importance.html

9. QSEN Institute. (n.d.). *QSEN competencies: Quality improvement (QI)*. https://qsen.org/competencies/pre-licensure-ksas/#quality_improvement

See Figure 9.5[10] for an illustration of the quality improvement process.

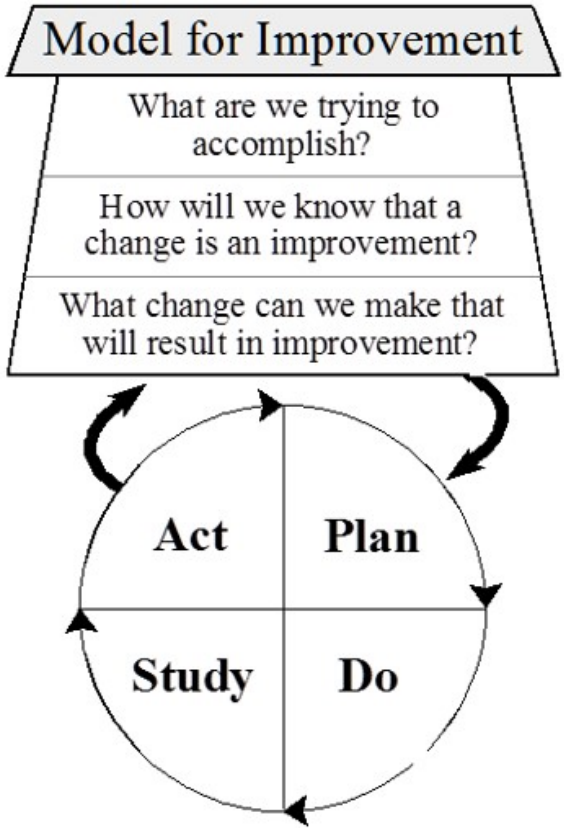


Figure 9.5 Quality Improvement Process

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 client 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

10. "Model_for_Improvement.jpg" by Cliffnorman is licensed under CC BY-SA 4.0

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 client care.

PDSA Fall Rates Example

Reducing Client Fall Rates

Objective: Decrease the client fall rate in the hospital by 10% within one year.

Plan

1. **Identify the Focus:** The QI project will focus on reducing client falls in the hospital.
2. **Determine What to Measure:** The primary metric will be the fall rate, calculated as the number of falls per 1,000 client days.
3. **Collect Data:** Baseline fall rates will be collected for the past year to understand current performance.
4. **Set Goals:** Aim to reduce the fall rate by 10% within one year.
5. **Develop a Timeline:**
    - **Initial Planning and Baseline Data Collection:**

Month 1
    - **Intervention Implementation:** Months 2-4
    - **Data Collection and Monitoring:** Months 2-12
    - **Initial Data Analysis:** Month 6
    - **Final Data Analysis and Review:** Month 12

Do

1. **Implement Interventions:** Conduct fall prevention training sessions for all nursing staff. Ensure that client rooms are free from clutter and that non-slip mats are in place. Install bed alarms and provide non-slip socks for clients. Implement a protocol for frequent rounding, especially for high-risk clients.
2. **Data Collection:** Continuously collect data on fall incidents, including the circumstances of each fall.

Study

1. **Data Analysis:** Review the fall rates monthly and compare them to the baseline data. Analyze trends and identify any patterns in the fall incidents. Determine if the interventions are associated with a reduction in fall rates.
2. **Outcome Evaluation:** Assess whether the goal of a 10% reduction in fall rates is being met. Identify any unexpected outcomes.

Act

1. **Discuss Outcomes:** Hold meetings with the health care team to discuss the results. Identify barriers to successful implementation (e.g., lack of compliance with protocols, insufficient training). Recognize strengths (e.g., effective

use of bed alarms, positive feedback from staff).

2. **Make Adjustments: I**f the fall rate has not decreased as expected, identify additional changes that might be needed (e.g., more frequent training, adjusting the rounding protocol). If successful, consider ways to further enhance the fall prevention program.
3. **Continuous Improvement:** Use the findings to plan the next cycle of improvements. Set new goals based on the outcomes and continue the PDSA cycle to maintain and further improve client safety

See Figure 9.6[11] for an illustration comparing the QI process to the nursing process.

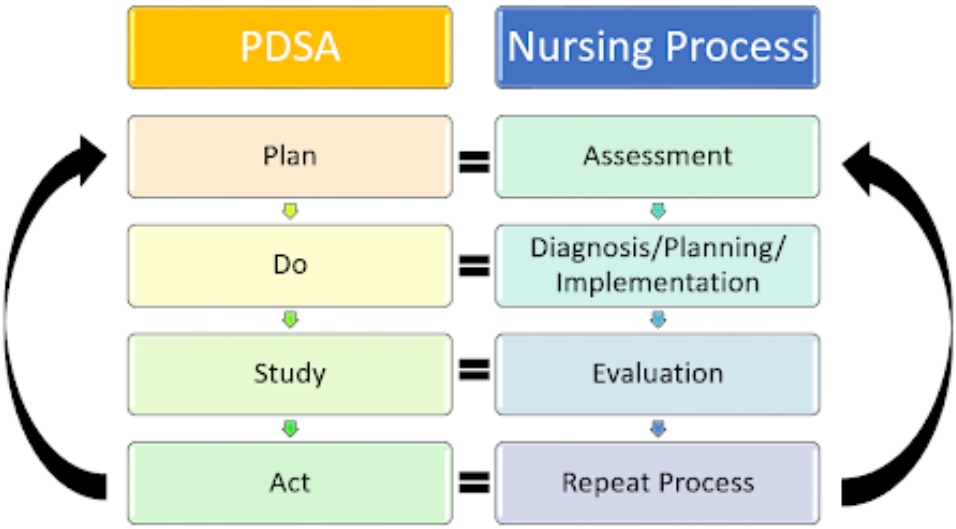


Figure 9.6 Comparison of the QI Process and the Nursing Process (Source: Amy Tyznik, MPTC)

It is important to note that quality improvement is different from nursing

11. "Comparison_QI Process_Nursing Process.jpg" by Amy Tyznik, MPTC for Open RN is licensed under CC BY 4.0

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.[12]

Barriers to Quality Improvement

Barriers to quality improvement (QI) in health care organizations can be multifaceted, arising from a range of systemic, cultural, and practical challenges. One of the primary barriers is resistance to change among health care professionals. This resistance can stem from a lack of understanding of QI principles, fear of additional workload, or skepticism about the effectiveness of new practices. Overcoming this barrier requires robust education and training programs that highlight the benefits of QI initiatives and provide staff with the skills and knowledge needed to implement changes effectively. Also, having transparent conversations, discussing the process steps, and engaging staff questions are paramount.[13]

Another significant barrier is inadequate data management systems. Quality improvement relies heavily on accurate and timely data to identify areas for improvement, track progress, and measure outcomes. However, many health care organizations struggle with fragmented or outdated information systems that hinder data collection and analysis. Investing in modern, integrated health information technologies can facilitate better data

12. Agency for Healthcare Research and Quality. (2013). Module 4. Approaches to quality improvement. *Practice facilitation handbook*. https://www.ahrq.gov/ncepcr/tools/pf-handbook/mod4.html

13. Giannitrapani, K., Satija. A., Ganesh, A., Gamboa, R., Fereydooni, S., Hennings, T., Chandrashekaran, S., Mickelsen, J., DeNatale, M., Spruijt, O., Bhatnagar, S., & Lorenz, K. A. (2021). Barriers and facilitators of using quality improvement to foster locally initiated innovation in palliative care services in India. *Journal of General Internal Medicine, 36*(2), 366-373. https://doi.org/10.1007/s11606-020-06152-y.

management and support QI efforts. It also saves significant manpower and staff resources, allowing for more rapid identification of issues and trends.[14]

Resource constraints also pose a substantial challenge to quality improvement in health care. Financial limitations, staffing shortages, and limited time can impede the ability to implement and sustain QI initiatives. Organizations may find it difficult to allocate the necessary resources for training, process redesign, and continuous monitoring. Addressing this barrier often requires strategic planning, prioritization of QI projects, and seeking external funding or partnerships to support initiatives. Many organizations may have quality departments while others may utilize nursing staff to complete QI initiatives.[15]

Cultural factors in health care organizations can also impede quality improvement. Organizational culture that does not prioritize client safety and continuous improvement can undermine QI efforts. This barrier can be addressed by fostering a culture of transparency, accountability, and collaboration. Leadership plays a crucial role in setting the tone and demonstrating a commitment to quality improvement. Engaging all levels of

14. Giannitrapani, K., Satija. A., Ganesh, A., Gamboa, R., Fereydooni, S., Hennings, T., Chandrashekaran, S., Mickelsen, J., DeNatale, M., Spruijt, O., Bhatnagar, S., Lorenz, K. A. (2021). Barriers and facilitators of using quality improvement to foster locally initiated innovation in palliative care services in India. *Journal of General Internal Medicine, 36*(2), 366-373. https://doi.org/ 10.1007/s11606-020-06152-y.

15. Alexander, C., Tschannen, D., Argetsinger, D., Hakim, H., & Milner, K. A. (2022). A qualitative study on barriers and facilitators of quality improvement engagement by frontline nurses and leaders. *Journal of Nursing Management, 30*(3), 694-701. https://doi.org/10.1111/jonm.13537.

staff in QI processes and celebrating successes can help build a positive culture that supports ongoing improvement.[16]

Lastly, regulatory and policy constraints can limit the scope and flexibility of QI initiatives. Health care organizations operate within a complex regulatory environment that can sometimes create barriers to innovative practices. Navigating these regulations while attempting to implement QI can be challenging. Advocacy for policy changes that support QI, along with a thorough understanding of existing regulations, can help organizations find ways to work within or adapt to these constraints.[17]

16. Alexander, C., Tschannen, D., Argetsinger, D., Hakim, H., & Milner, K. A. (2022). A qualitative study on barriers and facilitators of quality improvement engagement by frontline nurses and leaders. *Journal of Nursing Management, 30*(3), 694-701. https://doi.org/10.1111/jonm.13537.

17. Alexander, C., Tschannen, D., Argetsinger, D., Hakim, H., & Milner, K. A. (2022). A qualitative study on barriers and facilitators of quality improvement engagement by frontline nurses and leaders. *Journal of Nursing Management, 30*(3), 694-701. htttps://doi.org/10.1111/jonm.13537.

9.4 Evidence-Based Practice and Research

There are many ties between safe, quality client-centered care; evidence-based practice; research; and quality improvement. These concepts fall under the umbrella term "scholarly inquiry." All nurses should be involved in scholarly inquiry related to their nursing practice, no matter what agency they work. The American Nursing Association (ANA) Standard of Professional Performance called *Scholarly Inquiry* lists competencies related to incorporating evidence-based practice and research for all nurses. See the following box for a list of these competencies.[1]

Competencies of ANA's Scholarly Inquiry Standard of Professional Performance[2]

- Identifies questions in the health care or practice setting that can be answered by scholarly inquiry.
- Uses current evidence-based knowledge, combined with clinical expertise and health care consumer values and preferences, to guide practice in all settings.
- Participates in the formulation of evidence-based practice.
- Uses evidence to expand knowledge, skills, abilities, and judgement; to enhance role performance; and to increase knowledge of professional issues for themselves and others.
- Shares peer-reviewed, evidence-based findings with

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

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

colleagues to integrate knowledge into nursing practice.
- Incorporates evidence and nursing research when initiating changes and improving quality in nursing practice.
- Articulates the value of research and scholarly inquiry and their application to one's practice and health care setting.
- Promotes ethical principles of research in practice and the health care setting.
- Reviews nursing research for application in practice and the health care setting.

Reflective Questions

1. What *Scholarly Inquiry* competencies have you already demonstrated during your nursing education?
2. What *Scholarly Inquiry* competencies are you most interested in mastering?
3. What questions do you have about the ANA's *Scholarly Inquiry* competencies?

Nursing practice should be based on solid evidence that guides care and ensures quality. Evidence-based practice (EBP) is the foundation for providing effective and efficient health care that promotes improved client outcomes. **Evidence-based practice** is defined by the American Nurses Association as, "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 client, family, group,

community, and population preferences and values."[3] See Figure 9.7[4] for an illustration of evidence-based practice.



Figure 9.7 Evidence-based Practice

Evidence-based practice is the foundation nurses rely on to ensure their interventions, policies, and procedures are based on data supporting positive client outcomes. EBP relies on scholarly research that generates new nursing knowledge, as well as quality improvement processes that review client outcomes resulting from current nursing practice, to continually improve quality care. EBP encourages health care team members to incorporate new research findings into their practice, referred to as translating evidence into practice. Nurses must recognize the partnership between EBP and research; EBP cannot exist without continual scholarly research, and research requires nurses to evaluate research findings and incorporate them into their practice.[5]

3. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.
4. "Flowchart-sm.png" by Bates98 is licensed under CC BY_SA 4.0
5. Chien, L. Y. (2019). Evidence-based practice and nursing research. *The Journal of Nursing Research: JNR, 27*(4), e29. https://doi.org/10.1097/jnr.0000000000000346

- Read examples of nursing evidence-based projects from Johns Hopkins.

Newly graduated nurses may become immediately involved with evidence-based practice and quality improvement processes. The Quality and Safety Education (QSEN) project further elaborates on evidence-based practice for entry-level nurses with the definition of EBP as, "integrating best current evidence with clinical expertise and client/family preferences and values for delivery of optimal health care." See Table 9.4 for the knowledge, skills, and attitudes associated with the QSEN competency of evidence-based practice for entry-level nurses.

Table 9.4. QSEN: Knowledge, Skills, and Attitudes Associated With Evidence-Based Practice

Knowledge	Skills	Attitudes
Demonstrate knowledge of basic scientific methods and processes. Describe EBP to include the components of research evidence, clinical expertise, and client/family values.	Participate effectively in appropriate data collection and other research activities. Adhere to Institutional Review Board (IRB) guidelines. Base individualized care plan on client values, clinical expertise, and evidence.	Appreciate strengths and weaknesses of scientific bases for practice. Value the need for ethical conduct of research and quality improvement. Value the concept of EBP as integral to determining best clinical practice.
Differentiate clinical opinion from research and evidence summaries. Describe reliable sources for locating evidence reports and clinical practice guidelines.	Read original research and evidence reports related to area of practice. Locate evidence reports related to clinical practice topics and guidelines.	Appreciate the importance of regularly reading relevant professional journals.
Explain the role of evidence in determining best clinical practice. Describe how the strength and relevance of available evidence influences the choice of interventions in provision of client-centered care.	Participate in structuring the work environment to facilitate integration of new evidence into standards of practice. Question rationale for routine approaches to care that result in less-than-desired outcomes or adverse events.	Value the need for continuous improvement in clinical practice based on new knowledge.
Discriminate between valid and invalid reasons for modifying evidence-based clinical practice based on clinical expertise or client/family preferences.	Consult with clinical experts before deciding to deviate from evidence-based protocols.	Acknowledge own limitations in knowledge and clinical expertise before determining when to deviate from evidence-based best practices.

Reflective Questions: Read through the knowledge, skills, and attitudes in Table 9.4.

1. How are you currently integrating evidence-based practice when providing client care?
2. Where do you find information on current evidence-based practice?
3. Have you witnessed any routine approaches to care that resulted in less-than-desired outcomes or adverse events?
4. What else would you like to learn about evidence-based nursing practice?

Keeping Current on Evidence-Based Practices

Health care is constantly evolving with new technologies and new evidence-based practices. Nurses must dedicate themselves to being lifelong learners. After graduating from nursing school, it is important to remain current on evidence-based practices. Many employers subscribe to electronic evidence-based clinical tools that nurses and other health care team members can access at the bedside. Nurses also independently stay up-to-date on current evidence-based practice by reading nursing journals; attending national, state, and local nursing conferences; and completing continuing education courses. See the box below for examples of ways to remain current on evidence-based practices.

Examples of Evidence-Based Clinical Supports, Nursing Journals, and Conferences

- American Nurse (published by the American Nurses Association)
- American Journal of Nursing
- Cochrane Library
- ECRI Guidelines Trust
- Agency for Healthcare Research and Quality – EPC Evidence-Based Reports
- Journal of Clinical Nursing
- Lippincott Advisor
- Turning Research Into Practice (TRIP) Database
- UpToDate
- American Nursing Association – Events and Continuing Education

Research

Earlier in this chapter we discussed the process of quality improvement and the manner in which it is used to evaluate current nursing practice by determining where gaps exist and what improvements can be made. **Nursing research** is a different process than QI. The American Nurses Association (ANA) defines nursing research as, "Systematic inquiry designed to develop knowledge about issues of importance to the nursing professions."[6] The purpose of nursing research is to advance nursing practice through the discovery of new information. It is also used to provide scholarly

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

evidence regarding improved client outcomes resulting from evidence-based nursing interventions.

Nursing research is guided by a systematic, scientific approach. Research consists of reviewing current literature for recurring themes and evidence, defining terms and current concepts, defining the population of interest for the research study, developing or identifying tools for collecting data, collecting and analyzing the data, and making recommendations for nursing practice. As you can see, the scholarly process of nursing research is more complex than the Plan, Do, Study, Act process of QI and typically requires more time and resources to complete.[7]

Nurse researchers often use the PICOT format to organize the overall goals of the research project. The PICOT mnemonic assists nurses in answering the clinical question to be studied.[8] See Figure 9.8[9] for an image of PICOT. PICOT terms are further defined in the following box.

7. American Association of Colleges of Nursing. (2006). *Nursing research*. https://www.aacnnursing.org/News-Information/Position-Statements-White-Papers/Nursing-Research

8. Lansing Community College Library. (2025). *Nursing: PICOT*. https://libguides.lcc.edu/c.php?g=167860&p=6198388

9. "PICOT.png" by Kim Ernstmeyer for Chippewa Valley Technical College is licensed under CC BY 4.0



Figure 9.8 PICOT

PICOT

P: Population/Problem: Who are the clients that will be studied (e.g., age, race, gender, disease, or health status, etc.) and what problem is being addressed (e.g., mortality, morbidity, compliance, satisfaction, etc.)?

I: Intervention: What is the specific intervention to be implemented with the research population (e.g., therapy, education, medication, etc.)?

C: Comparison: What is the alternative intervention that will be used to compare to the treatment intervention (e.g., placebo, no intervention, different medication, etc.)?

O: Outcome: What will be measured and how will it be

measured and with what identified goal (e.g., fewer symptoms, increased satisfaction, reduced mortality, etc.)?

T: Time Frame: How long will the interventions be implemented and data collected for this research?

After the researcher has completed the PICOT question, these additional questions should also be considered to protect clients' rights and reduce the potential for ethical conflicts:

- Was the study approved by the Institutional Review Board (IRB)? The IRB, also known as an independent ethics committee, reviews research studies to protect the rights and welfare of participants.[10] Read more about ethics related to research in the "Ethical Practice" chapter.
- Were the participants protected? Researchers have the responsibility to protect human rights, uphold HIPAA, and respect the personal values of the participants.
- Did the benefits of the intervention outweigh the risk(s)? Researchers have the responsibility to identify if there is a possibility for increased harm to the clients because of the research project.
- Were informed consents obtained? All research participants must provide written informed consent before a study can begin. Researchers must ensure the participants were fully informed of the study, provided risks and benefits, and allowed to exit the study at any time.
- Were vulnerable populations protected? Populations of study that

10. U. S. Food & Drug Administration. (2025). *Institutional review boards frequently asked questions: Guidance for institutional review boards and clinical investigators.* https://www.fda.gov/regulatory-information/search-fda-guidance-documents/institutional-review-boards-frequently-asked-questions

include infants, minorities, children, elderly, socioeconomically disadvantaged, prisoners, etc., are considered vulnerable populations, and researchers must ensure their rights and safety are accounted for.

After the nurse researcher confirms participants' rights are protected and has established a PICOT question, the next step is to design the research study and review existing research. Research designs are categorized by the type of data that is collected and reviewed. See Figure 9.9[11] for an illustration of different types of research. The three basic types of nursing research are quantitative studies, qualitative studies, and meta-analyses. See definitions and examples of these types in the following box.

Types of Research

- **Quantitative Studies:** These studies provide objective data by using number values to explain outcomes. Researchers can use statistical analysis to determine the strength of the findings, as well as identify correlations.
  - View an example of an quantitative research study.
- **Qualitative Studies:** These studies provide subjective data, often focusing on the perception or experience of the participants. Data is collected through observations and open-ended questions and is often referred to as experimental data. Data is interpreted by recurring themes in participants' views and observations.
  - View an example of a qualitative research study.
- **Meta-Analyses:** A meta-analysis, also referred to as a "systematic review," compares the results of independent

11. "Quantitative_methods.png" by Remydiligent1 is licensed under CC BY-SA 4.0

research studies asking similar research questions. A meta-analysis often collects both quantitative and qualitative data to provide a well-rounded evaluation by providing both objective and subjective outcomes. This research design often requires more time and resources, but it also promotes consistency and reliability through the identification of common themes.

- View an example of a meta-analysis/systematic review.

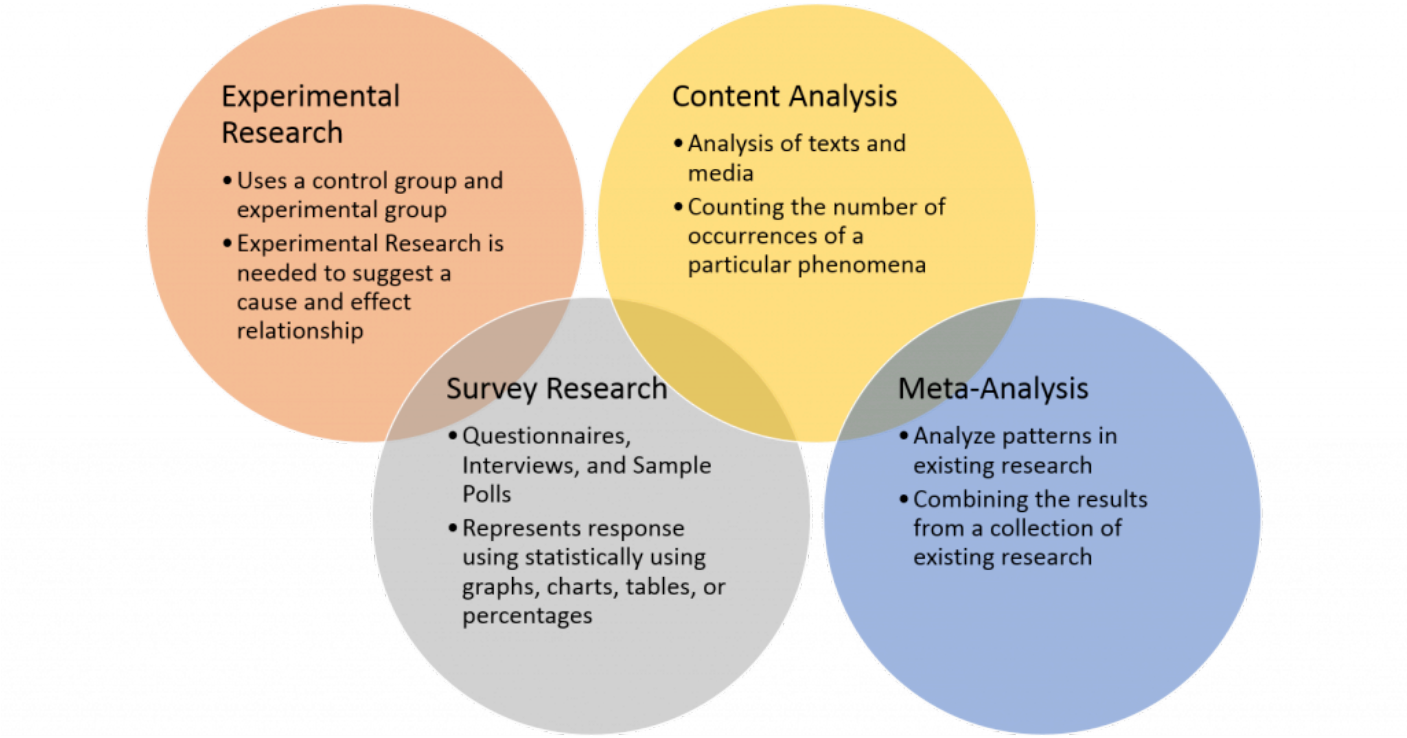


Figure 9.9 Research

Nurses must understand the types of research designs to accurately understand and apply the research findings. Additionally, only research from peer-reviewed scholarly journals should be used. Scholarly journals use a process called "peer review" to ensure high quality. An article that is **peer**

reviewed has been reviewed independently by at least two other academic experts in the same field as the author(s) to ensure accuracy.

Nurses must also be aware of the difference between primary and secondary sources of scholarly evidence. A **primary source** is the 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.

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



View QUT Library's Primary vs. secondary sources YouTube video.[12]

By understanding these basic research concepts, nurses can accurately implement current evidence-based practice based on continually evolving nursing research.

12. QUT Library. (2020, November 22). *Primary vs. secondary sources* [Video]. YouTube. All rights reserved. https://youtu.be/FZRxYfWYEBI

9.5 Spotlight Application

Joanne is a newly graduated nurse working on a general medical floor in a large urban teaching hospital. She is typically assigned between four and six clients during her shift depending on the acuity mix. Many of her clients are direct admit clients or are transferred from the emergency department. Joanne has recently noticed a significant delay on weekend shifts with room turnover and new client admittance.

Joanne voiced her concerns regarding the delays to her unit manager. Her manager agreed that room turnover delays on the weekend have significantly increased in recent months. She reported that she will investigate the delays further. A few weeks pass and Joanne's manager 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. Joanne's manager has voiced her concerns regarding the delays, but administration has been reluctant to hire additional staff. Joanne and her manager both feel strongly that investment in staff is needed.

Reflective Questions

1. What strategies might Joanne and her manager utilize to reflect the significance of these staff shortages?
2. How might they gather and present information to demonstrate the need for additional environmental services personnel?
3. What stakeholders would be important to engage in this discussion?
4. Create a PICOT question for this scenario.

When considering the impact of care delays in a health care organization, it is important to gather data to substantiate the significance of delayed care. Joanne and her manager might begin to look at organizational throughput or transfer data to determine how long clients are being held in emergency rooms or other settings during the weekend shifts compared to weekday shifts. Additionally, it would be important for the organization to determine if

these delayed admits impeded the ability of the emergency department to accept clients and if the organization was subsequently placed on client divert due to an inability to care for clients in the emergency room setting. Engaging house supervisors, charge nurses, informatics specialists, etc., may be helpful in determining the significance of the delay and potential quality implications. An example PICOT question to help examine this scenario may be structured as: What is the impact of one additional environmental services FTE compared to existing staffing patterns on organizational throughput times over a three-month period?

9.6 Learning Activities

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nursingmpc/?p=604#h5p-14

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nursingmpc/?p=604#h5p-15

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nursingmpc/?p=604#h5p-16

Test your knowledge using this NCLEX Next Generation-style Case Study. You may reset



- and resubmit your answers to this question an unlimited number of times.[1]

1. “Chapter 9, Assignment 1” by Travis Christman for OpenRN is licensed under CC BY-NC 4.0

IX Glossary

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

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

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

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 client, family, group, community, and population preferences and values.[1]

Informatics: Using information and technology to communicate, manage knowledge, mitigate error, and support decision-making.[2] This allows members of the health care team to share, store, and analyze health-related information.

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

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

2. QSEN Institute. (n.d.). *QSEN competencies: Quality improvement (QI).* https://qsen.org/competencies/pre-licensure-ksas/#quality_improvement

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

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.[3] The purpose of nursing research is to advance nursing practice through the discovery of new information. It is also used to provide scholarly evidence regarding improved client outcomes resulting from nursing interventions.

National 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.

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.

Qualitative studies: 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

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

experimental data. Data is interpreted by developing themes in participants' views and observations.

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): A systematic process using measurable data to improve health care services and the overall health status of clients. The QI process includes the steps of Plan, Do, Study, and Act.

Quantitative studies: 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.

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.

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 clients' needs.

PART X

CHAPTER 10 - ADVOCACY

10.1 Advocacy Introduction

Learning Objectives

- Assess the effects of current health care policies on health care consumers and nursing practice
- Explore the role of professional organizations in nursing practice
- Discuss legislative policy-making activities that influence nursing practice and health care
- Examine various positions on unions and collective bargaining
- Compare various workplace advocacy models

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 “client 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.[1]

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.

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

1. National Academies of Sciences, Engineering, and Medicine. (2021). *The Future of nursing 2020-2030: Charting a path to achieve health equity*. The National Academies Press. https://doi.org/10.17226/25982

Advocacy

The American Nurses Association (ANA) emphasizes that advocacy is fundamental to nursing practice in every setting. See Figure 10.1[1] for an illustration of advocacy. **Advocacy** is defined as the act or process of pleading for, supporting, or recommending a cause or course of action. Advocacy may be for individuals, groups, organizations, communities, society, or policy issues[2]:

- **Individual:** The nurse educates health care consumers so they can consider actions, interventions, or choices related to their own personal beliefs, attitudes, and knowledge to achieve the desired outcome. In this way, the health care consumer learns self-management and decision-making.[3]
- **Interpersonal:** The nurse empowers health care consumers by providing emotional support, assistance in obtaining resources, and necessary help through interactions with families and significant others in their social support network.[4]
- **Organization and Community:** The nurse supports cultural and social transformation of organizations, communities, or populations. Registered

1. "Advocacy_-_The_Noun_Project.svg" by OCHA Visual Information Unit is licensed under CC0

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

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

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

nurses understand their obligation to help improve environmental and societal conditions related to health, wellness, and care of the health care consumer.[5]

- **Policy:** The nurse promotes inclusion of the health care consumers' voices into policy, legislation, and regulation about issues such as health care access, reduction of health care costs and financial burden, protection of the health care consumer, and environmental health, such as safe housing and clear water.[6]

Advocacy at each of these levels will be further discussed in later sections of this chapter.



Figure 10.1 Advocacy

Advocacy is one of the ANA's Standards of Professional Performance. The Standards of Professional Performance are "authoritative statements of the

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

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

actions and behaviors that all registered nurses, regardless of role, population, specialty, and setting, are expected to perform competently."[7] See the following box to read the competencies associated with the ANA's *Advocacy* Standard of Professional Performance.[8]

Competencies of ANA's Advocacy Standard of Professional Performance[9]

- Champions the voice of the health care consumer.
- Recommends appropriate levels of care, timely and appropriate transitions, and allocation of resources to optimize outcomes.
- Promotes safe care of health care consumers, safe work environments, and sufficient resources.
- Participates in health care initiatives on behalf of the health care consumer and the system(s) where nursing happens.
- Demonstrates a willingness to address persistent, pervasive systemic issues.
- Informs the political arena about the role of nurses and the vital components necessary for nurses and nursing to provide optimal care delivery.
- Empowers all members of the health care team to include

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

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

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

the health care consumer in care decisions, including limitation of treatment and end-of-life care.
- Embraces diversity, equity, inclusivity, health promotion, and health care for individuals of diverse geographic, cultural, ethnic, racial, gender, and spiritual backgrounds across the life span.
- Develops policies that improve care delivery and access for underserved and vulnerable populations.
- Promotes policies, regulations, and legislation at the local, state, and national levels to improve health care access and delivery of health care.
- Considers societal, political, economic, and cultural factors to address social determinants of health.
- Role models advocacy behavior.
- Addresses the urgent need for a diverse and inclusive workforce as a strategy to improve outcomes related to the social determinants of health and inequities in the health care system.
- Advances policies, programs, and practices within the health care environment that maintain, sustain, and restore the environment and natural world.
- Contributes to professional organizations.

Reflective Questions

1. What *Advocacy* competencies have you already demonstrated during your nursing education?
2. What *Advocacy* competencies are you most interested in

performing next?

3. What questions do you have about ANA's *Advocacy* competencies?

10.3 Individual and Interpersonal Advocacy

As discussed previously, the American Nurses Association (ANA) defines advocacy at the individual level as educating health care consumers so they can consider actions, interventions, or choices related to their own personal beliefs, attitudes, and knowledge to achieve the desired outcome. In this way, the health care consumer learns self-management and decision-making.[1] Advocacy at the interpersonal level is defined as empowering health care consumers by providing emotional support, assistance in obtaining resources, and necessary help through interactions with families and significant others in their social support network.[2]

What does advocacy look like in a nurse's daily practice? The following are some examples provided by an oncology nurse[3]:

- **Ensure Safety.** Ensure the client is safe when being treated in a health care facility and when they are discharged by communicating with case managers or social workers about the client's need for home health or assistance after discharge so it is arranged before they go home.
- **Give Clients a Voice.** Give clients a voice when they are vulnerable by staying in the room with them while the doctor explains their diagnosis and treatment options to help them ask questions, get answers, and translate information from medical jargon.
- **Educate.** Educate clients on how to manage their current or chronic

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

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

3. Nitzky, A. (2018). Six ways nurses can advocate for patients. *Oncology Nursing News*. https://www.oncnursingnews.com/view/six-ways-nurses-can-advocate-for-patients

conditions to improve the quality of their everyday life. For example, clients undergoing chemotherapy can benefit from the nurse teaching them how to take their anti-nausea medication in a way that will be most effective for them and will allow them to feel better between treatments.

- **Protect Client Rights.** Know clients' wishes for their care. Advocacy may include therapeutically communicating a client's wishes to an upset family member who disagrees with their choices. In this manner, the client's rights are protected and a healing environment is established.
- **Double-Check for Errors.** Know that everyone makes mistakes. Nurses often identify, stop, and fix errors made by interprofessional team members. They flag conflicting orders from multiple providers and notice oversights. Nurses should read provider orders and carefully compare new orders to previous documentation. If an order is unclear or raises concerns, a nurse should discuss their concerns with another nurse, a charge nurse, a pharmacist, or the provider before implementing it to ensure client safety.
- **Connect Clients to Resources.** Help clients find resources inside and outside the hospital to support their well-being. Know resources in your agency, such as case managers or social workers who can assist with financial concerns, advance directives, health insurance, or transportation concerns. Request assistance from agency chaplains to support spiritual concerns. Promote community resources, such as client or caregiver support networks, Meals on Wheels, or other resources to meet their needs.

Nurses must recognize their unique position in client advocacy to empower individuals to provide them with the support and resources to make their best judgment. The intimate and continuous nature of the nurse-client relationship places nurses in a prime position to identify and address the needs and concerns of their clients. This relationship is built on trust, empathy, and consistent interaction, which allows nurses to gain a deep understanding of their clients' values, preferences, and personal circumstances. By leveraging this close proximity and strong rapport, nurses

can effectively advocate for their clients, ensuring that their voices are heard, and their wishes are respected in all aspects of care.[4]

The power of the nurse-client relationship extends beyond the immediate clinical environment. Nurses often act as liaisons between clients and the broader health care team, facilitating communication and ensuring that client preferences are integrated into care plans. This advocacy role is crucial in navigating complex health care systems where clients may feel overwhelmed or marginalized. Nurses can help demystify medical jargon, explain treatment options, and support clients in making informed decisions that align with their values and goals. Through education and emotional support, nurses empower clients to take an active role in their own care, enhancing client autonomy and satisfaction.[5]

In addition to direct client care, nurses play a pivotal role in identifying systemic issues that affect client outcomes. Their frontline perspective provides valuable insights into the barriers clients face in accessing quality care, such as socioeconomic challenges, cultural barriers, and institutional policies. By advocating for policy changes and improvements in health care delivery, nurses contribute to creating a more equitable and client-centered health care system. Their advocacy efforts can lead to the implementation of practices and policies that better address the needs of diverse client populations, ultimately improving health outcomes on a broader scale.[6]

4. Nsiah, C., Siakwa, M., & Ninnoni, J. P. K. (2019). Registered nurses' description of patient advocacy in the clinical setting. *Nursing Open, 6*(3), 1124-1132. https://doi.org/10.1002/nop2.307.

5. Nsiah, C., Siakwa, M., & Ninnoni, J. P. K. (2019). Registered nurses' description of patient advocacy in the clinical setting. *Nursing Open, 6*(3), 1124-1132. https;//doi.org/10.1002/nop2.307.

6. Nsiah, C., Siakwa, M., & Ninnoni, J. P. K. (2019). Registered nurses' description of

Nurses' advocacy is also essential in situations where clients are unable to speak for themselves, such as in cases of severe illness, disability, or end-of-life care. In these instances, nurses must be vigilant in recognizing and addressing the needs of vulnerable clients, ensuring that their rights and dignity are upheld. This may involve working closely with families and caregivers, coordinating with interdisciplinary teams, and navigating ethical dilemmas to provide the best possible care for the client.

patient advocacy in the clinical setting. *Nursing Open, 6*(3), 1124-1132. https://doi.org/10.1002/nop2.307.

10.4 Community and Organization Advocacy

Nurses advocate for issues in their communities and their organizations.

Addressing Social Determinants of Health

Advocacy is commonly perceived as acting on behalf of a client, but it can be a much broader action than affecting a single client and their family members. Nurses advocate for building healthier communities by addressing **social determinants of health (SDOH)**. 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. Social determinants of health (SDOH) have a major impact on people's health, well-being, and quality of life. See Figure 10.2[1] for an illustration of SDOH.[2]

1. "Healthy People 2030 SDOH Graphic.png" by U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion is in the Public Domain. Access for free at https://health.gov/healthypeople/objectives-and-data/social-determinants-health

2. Healthy People 2030. (n.d.). *Social determinants of health.* U.S. Department of Health and Human Services. https://health.gov/healthypeople/objectives-and-data/social-determinants-health

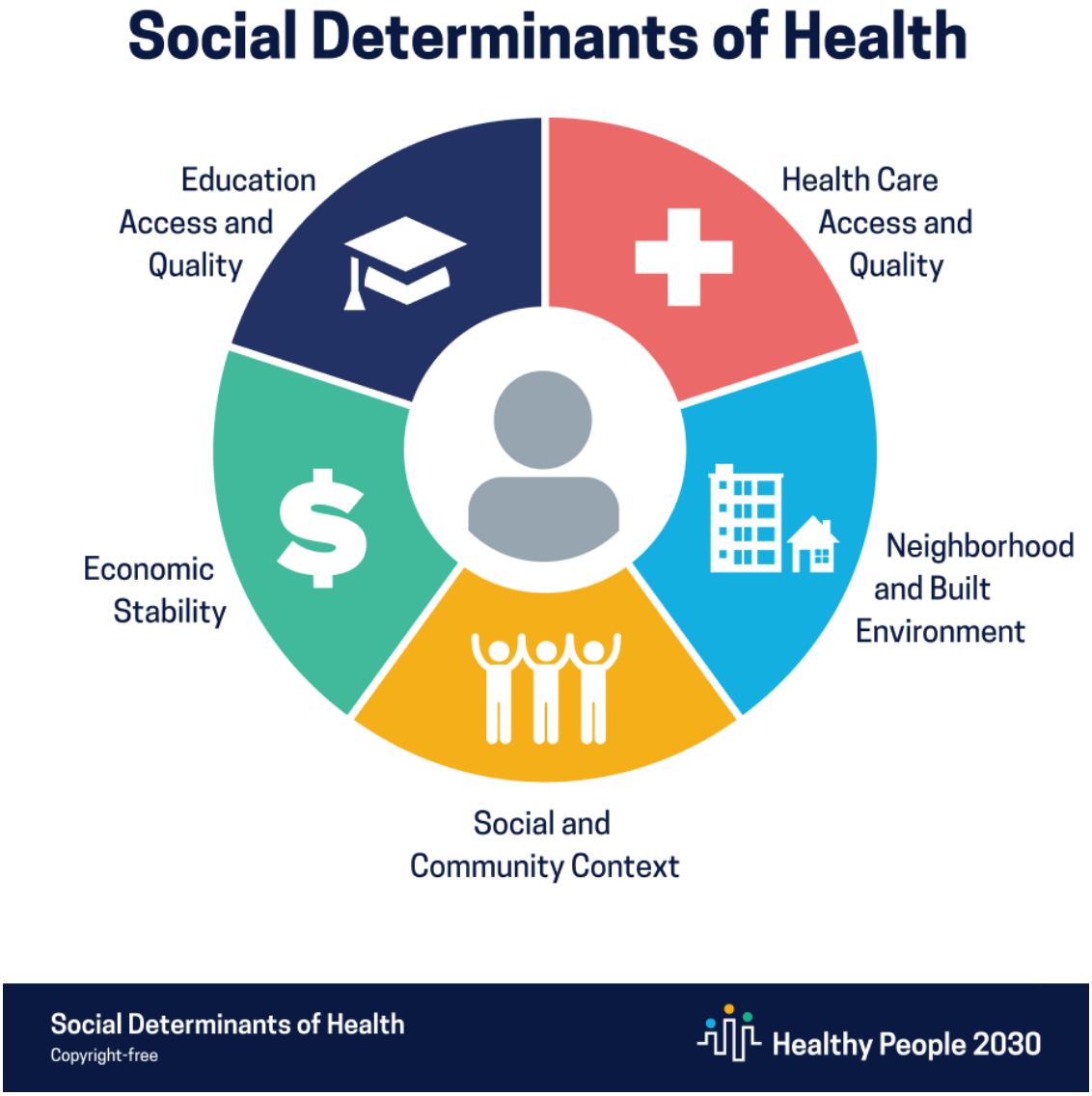


Figure 10.2 Social Determinants of Health

Specific examples of addressing SDOH include the following goals:

- Improving safe housing and public transportation
- Decreasing discrimination and violence
- Expanding quality education and job opportunities
- Increasing access to nutritious foods and physical activity opportunities
- Promoting clean air and clean water
- Enhancing language and literacy skills[3]

SDOH contribute to health disparities and inequities among different socioeconomic groups. For example, individuals who don't have access to grocery stores with healthy foods are less likely to have good nutrition, increasing their risk for health conditions like heart disease, diabetes, and obesity, and potentially lowering their life expectancy relative to people who do have access to healthy foods.[4]

One of Healthy People 2030's goals specifically relates to advocacy regarding SDOH. The goal states, "Create social, physical, and economic environments that promote attaining the full potential for health and well-being for all." Across the United States, people and organizations at the local, state, territorial, tribal, and national levels are working hard to improve health and reduce health disparities by addressing SDOH.[5] Read more information about these advocacy efforts in the following box.

> Read more about efforts addressing SDOH at Healthy People 2030.

Understanding and addressing SDOH is crucial for effective health care advocacy, as it provides a comprehensive view of the various elements that

3. Healthy People 2030. (n.d.). *Social determinants of health.* U.S. Department of Health and Human Services. https://health.gov/healthypeople/objectives-and-data/social-determinants-health

4. Healthy People 2030. (n.d.). *Social determinants of health.* U.S. Department of Health and Human Services. https://health.gov/healthypeople/objectives-and-data/social-determinants-health

5. Healthy People 2030. (n.d.). *Social determinants of health.* U.S. Department of Health and Human Services. https://health.gov/healthypeople/objectives-and-data/social-determinants-health

impact clients' well-being. These determinants include economic stability, education, social and community context, health and health care access, and the neighborhood and built environment.

- **Economic stability:** Factors such as income, employment, and financial security directly affect individuals' ability to access health care services, afford medications, and maintain healthy lifestyles. Advocates can use this understanding to push for policies that address income inequality, create job opportunities, and provide financial support for those in need. By advocating for economic policies that reduce poverty and enhance financial stability, health care advocates can help mitigate one of the most significant barriers to health.
- **Education:** Higher levels of education are associated with better health outcomes, as education enhances health literacy, empowers individuals to make informed health decisions, and provides opportunities for better employment. Advocacy efforts can focus on improving access to quality education, promoting health education programs, and supporting lifelong learning initiatives. By addressing educational disparities, advocates can contribute to long-term improvements in health and well-being.
- **Social and community context:** Strong social support and community connections can improve mental health, reduce stress, and foster a sense of belonging, all of which are essential for overall well-being. Health care advocates can work to strengthen community resources, promote social cohesion, and address issues such as discrimination and violence. Efforts to build safer, more supportive communities can lead to healthier and more resilient populations.
- **Access to health and health care:** Barriers such as lack of insurance, geographic limitations, and inadequate health care infrastructure can prevent individuals from receiving necessary care. Advocacy in this area can focus on expanding health care coverage, improving health care delivery systems, and ensuring that marginalized populations have access to quality care. By promoting equitable access to health care services, advocates can help reduce health disparities and improve outcomes for

underserved communities.

- **Neighborhood and environment:** Poor housing conditions, lack of safe recreational spaces, and limited access to nutritious food can lead to adverse health outcomes. Advocates can work to improve urban planning, support affordable housing initiatives, and promote policies that ensure access to healthy food options. Creating healthier environments can have a substantial impact on public health.[6]

Analysis of individuals' social determinants of health provides a holistic understanding of the factors that influence health. By addressing economic stability, education, social and community context, health and healthcare access, and the neighborhood and built environment, advocates can develop comprehensive strategies to improve health outcomes and reduce disparities. Recognizing and addressing SDOH enables healthcare advocates to promote policies and initiatives that create healthier, more equitable communities, ultimately leading to better health for all.

Organization Advocacy

Nurses advocate for organizational issues in the nursing profession and the workplace through participation in unions, collective bargaining, workplace advocacy models, and professional organizations.

Unions and Collective Bargaining

A nursing union is a type of labor union that advocates for the interest of its nurse members. According to the Bureau of Labor Statistics, 20 percent of

6. Healthy People 2030. (n.d.). *Social determinants of health.* U.S. Department of Health and Human Services. https://health.gov/healthypeople/objectives-and-data/social-determinants-health

RNs and 10 percent of LPNs/VNs in the United States are union members.[7] Nursing union goals are typically to advocate for the improvement of benefits, wages, client safety, and workplace conditions. Advocacy is accomplished by collective bargaining. **Collective bargaining** refers to the negotiation of wages and other conditions of employment by an organized body of employees. See Figure 10.3[8] for an image of a union worker.



Figure 10.3 Union Worker

Although there is no single union that represents all nurses across the country, there are several nursing unions such as the National Nurses United, SEIU United Healthcare, and The United Food and Commercial Workers International Union. The National Nurses United union is the largest nursing union in the United States and has joined with other unions across the

7. Rowland, T. (2020). *The pros and cons of nursing unions* [Blog]. Soliant. https://blog.soliant.com/nursing/the-pros-and-cons-of-nursing-unions/

8. "Debbie_Stabenow_marches_on_Labor_Day_2017_21318919_10155403813215528_8762450224354658172_o.jpg" by Office of Debbie Stabenow is in the Public Domain

country to address unsafe staffing. Read more about these unions in the following box.

Read more about nursing unions:

- National Nurses United
- SEIU United Healthcare
- The United Food and Commercial Workers International Union

Nursing unions can provide several potential benefits to the nursing profession. They may improve job security, improve working conditions, negotiate for better pay and benefits, protect seniority, establish staffing ratios, address workplace violence and incivility, and provide a well-defined grievance process. Unionized nurses earn an average of $200-$400 more per week than nonunionized nurses. Unions assist with grievance processes for resolving disagreements between employees and management. Examples of grievances include the promotion of one employee over another who has more seniority, disputes over holiday pay, and problems related to employee discipline.[9]

However, there are also potential disadvantages of unions, such as the cost of dues (up to $90/month per nurse), difficulty in removal of incompetent nurses, mandatory strikes with no pay, the issue of seniority taking precedence over good performance, and creation of working environments that can be adversarial between management and nursing. Additionally, many nursing unions are not organized or led by nurses, causing the belief that some unions are more interested in collecting dues than in improving the work environment for nurses. Although there has been research to

9. Rowland, T. (2020). *The pros and cons of nursing unions* [Blog]. Soliant. https://blog.soliant.com/nursing/the-pros-and-cons-of-nursing-unions/

determine if unions are good for nurses and good for clients, the findings are not conclusive. Some studies have shown that unionized hospitals have lower mortality rates, but higher failure-to-rescue and pressure injury rates. Another study found that unionized hospitals had higher levels of job dissatisfaction but higher levels of nurse retention.[10,11]

Workplace Advocacy Models

Nurses can advocate for improvements in the workplace via various mechanisms, such as shared governance and the ANCC Magnet Recognition Program, and by participation in professional organizations. Nurses can also seek legislative solutions for workplace problems by advocating for legislation such as whistleblower protection.[12] Whistleblower protection is further discussed in the "Policy Advocacy" section of this chapter.

SHARED GOVERNANCE

Shared governance refers to a shared leadership model between management and employees working together to achieve common goals. Shared governance models are believed to promote nurses' empowerment, engagement, autonomy, accountability, and collaboration while also striving to improve client safety, quality care, and positive outcomes. This style of

10. Dube, A. Kaplan, E., & Thompson, O. (2016). Nurse unions and patient outcomes. *ILR Review, 69*(4), 803-833. https://doi.org/10.1177%2F0019793916644251

11. Seago, J. A., Spetz, J., Ash, M., Herrera, C., & Keane, D. (2011). Hospital RN job satisfaction and nurse unions. *Journal of Nursing Administration, 41*(3), 109-114. https://doi.org/10.1097/nna.0b013e31820c726f

12. American Nurses Association. (n.d.). *Five opportunities and challenges for workforce advocacy program.* https://www.nursingworld.org/practice-policy/advocacy/

management encourages and empowers nurses to be part of making decisions that impact their daily work environments. When organizations utilize a shared governance model, employees feel valued and invested in the organization's success. Nurse engagement also improves both staff and client outcomes, such as increased job satisfaction and client satisfaction.[13] Implementation of a shared governance model has led to organizational cost savings, decrease in meeting times, fewer sick days used by employees, and a decrease in staff turnover.[14] See the following box for an example of effective shared governance.

Example of Effective Shared Governance[15]

A busy telemetry unit wants to address issues with low client satisfaction scores and an increase in both central line and indwelling catheter days. A quality improvement project is instituted by a multidisciplinary team that works to communicate the project's goals and objectives, respecting each team member's expertise and input. The team initiates daily multidisciplinary rounding on the unit. Six months after the

13. Kroning, M., & Hopkins, K. (2019). Healthcare organizations thrive with shared governance. *Nursing Management, 50*(5), 13-15. https://doi.org/10.1097/01.numa.0000557781.40049.2d

14. Anthony, M. (2004). Shared governance models: The theory, practice, and evidence. *Online Journal of Issues in Nursing, 9*(1), 7. https://pubmed.ncbi.nlm.nih.gov/14998357/

15. Kroning, M., & Hopkins, K. (2019). Healthcare organizations thrive with shared governance. *Nursing Management, 50*(5), 13-15. https://doi.org/10.1097/01.numa.0000557781.40049.2d

implementation of multidisciplinary rounding, client satisfaction scores improve, and a decrease in both central line and indwelling catheter days is noted. Multidisciplinary rounding provides a collaborative team approach, acknowledging the expertise and leadership role of each discipline with the same end goal of improving client outcomes.

MAGNET RECOGNITION PROGRAM

Nurses can advocate for their excellence in the workplace by participating in activities required for Magnet Recognition. As previously discussed in this book, the **Magnet Recognition Program** is an organizational credential from the American Nurses Credentialing Center (ANCC) recognizing quality client outcomes, nursing excellence, and innovations in professional nursing practice. The Magnet Recognition Program requires nursing advocacy in the areas of technology, education, policies, and process development. This advocacy is accomplished by creating unit-based practice councils who meet regularly to discuss unit policies, practices, and outcomes. Additionally, an organization-wide practice council includes a representative from each unit council and reviews organizational-wide policies and practices. Read more about the Magnet Recognition Program in the following box.

- Read more about the Magnet Recognition Program.

Professional Nursing Organizations

Professional organizations provide easy access to nursing advocacy work being done across the nation and the world. There are over 100 local, state, and national organizations that advocate for the nursing profession.

Professional nursing organizations may advocate for specific nursing issues in certain areas of practice, such as critical-care nursing (American Association of Critical-Care Nurses, AACN) or broader national nursing issues, such as the American Nurses Association (ANA). Professional organizations also provide opportunities for continuing education, advanced certification, and participation in political action committees. Membership in state and national organizations helps nurses stay up-to-date on current evidence-based practices and research findings.

- Review a list of national, state, and international nursing organizations.

10.5 Policy Advocacy

National, state, and local policies impact nurses at all levels of care, from nurse administrators to bedside nurses, making it essential for nurses to take an active role in advocating for their clients, their profession, and their community. Nurses advocate for improved access to basic health care, enhanced funding of health care services, and safe practice environments by participating in policy discussions. Nurses also participate in state and national policy discussions affecting nursing practice. For example, nurses advocate for the removal of practice barriers so nurses can practice according to the full extent of their education, certification, and licensure; address reimbursement based on the value of nursing care; and expand funding for nursing education.[1]

When advocating, nurses must view themselves as knowledgeable professionals who have the power to influence policy and decision-makers. A nurse can advocate for improved policies through a variety of pathways. Each method provides a unique opportunity for the nurse to impact the health of individuals and communities, the profession of nursing, and the overall health care provided to clients. These are few easy ways for nurses to get involved:

- Becoming involved in professional nursing organizations
- Engaging in conversations with local, state, and federal policymakers on health care related issues
- Participating in shared governance committees regarding workplace policies

Health Care Legislative Policies

Legislative policies are external rules and regulations that impact health care practice and policy at the national, state, and local levels. These regulations

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

seek to protect clients and nurses by defining safe practices, quality standards, and requirements for health care organizations and insurance companies. Nurses have been involved in the adoption of these rules and regulations and continue to advocate for new and updated legislation affecting health care.

Examples of federal legislation addressing health care include advocating for the Patient's Bill of Rights, client privacy and confidentiality, improved access to health care, and protections for individuals who report unethical or illegal activities in the health care environment (i.e., whistleblower legislation). Examples of legislation at the state level includes topics such as right-to-die and physician-assisted suicide, medicinal marijuana use, and nurse-to-client staffing ratios.

Review how client rights are defined by policies at the federal, state, and organizational levels in the following box.

Client's Rights Defined at Multiple Levels

In 1973 the American Hospital Association (AHA) adopted the Patient's Bill of Rights. The bill has since been updated and adapted for use throughout the world in all health care settings, but, in general, it safeguards a client's right to accurate and complete information, fair treatment, and self-determination when making health care decisions. In 2010 the Affordable Care Act was passed at the federal level. It included additional client rights and protections for health care consumers in the areas of preexisting conditions, choice of providers, and limited lifetime coverage limits imposed by insurance companies.

States further define client rights beyond federal regulations and provide specific rights of health care consumers in their state. For example, Wisconsin's Department of Health Services defines

treatment rights, protections for records privacy and access, communication rights, personal rights, and privacy rights.

- Read more about Patient Rights in the American Healthcare System.

- Visit the CMS web page to read more about the Affordable Care Act and the revised Patient's Bill of Rights.

- Research advocacy policies in your state. Here is Wisconsin's law regarding client rights.

Nurses' Roles in Legislative Policies

With over four million registered nurses in the United States, nursing has a powerful voice that can significantly influence health care legislation. Nurses have been recognized as a major influence on health care policies related to client safety and quality care. They can become involved in policy making at the state and federal level by joining a professional nursing organization, communicating with their state representatives, or running for political office to take an active role in policy creation.

Most professional nursing organizations have a legislative policy committee that reviews proposed federal and state legislation and makes recommendations for change, endorses the legislation, or leads opposition. For example, organizations such as the American Nurses Association (ANA), National League of Nursing (NLN), and state nursing associations inform members of current legislative initiatives, provide comprehensive reviews,

and encourage members to contact their representatives about pending legislation.

> Read more about current advocacy efforts by the Wisconsin Nurses Association.

Whistleblowing

Nurses are expected to follow federal, state, and agency policies and regulations, be proactive in policy development, and speak up when policies are not being followed. When regulations and policies are not being followed, nurses must advocate for public safety by reporting the problem to a higher authority. Whistleblowing refers to reporting a significant concern to your supervisor, the federal or state agency responsible for the regulation, or in the case of criminal activity, to law enforcement agencies. A **whistleblower** is a person who exposes any kind of information or activity that is deemed illegal, unethical, or not correct within an organization. See Figure 10.5[2] for federal instructions regarding whistleblowing.

2. "Whistleblowing.pdf"" by United States Office of Special Counsel is in the Public Domain

Whistleblowing

A "whistleblower" discloses information he or she reasonably believes evidences:

- A violation of any law, rule or regulation
- Gross mismanagement
- A gross waste of funds
- An abuse of authority
- A substantial and specific danger to public health
- A substantial and specific danger to public safety

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Figure 10.5 Whistleblowing

Whistleblowing typically begins with reporting the wrongdoing to a supervisor and following the internal chain of command. This first step of reporting allows the organization to correct the issue internally. However, there may be situations where an individual may need to directly report to an external authority, such as a State Board of Nursing or another regulatory agency. For example, any person who has knowledge of conduct by a licensed nurse violating state or federal law may report the alleged violation to the State Board of Nursing where the conduct occurred.

Acting as a whistleblower can be a difficult decision because the individual may be labelled "disloyal" or potentially face retaliatory actions by the accused individual or organization. Although there are legal protections for whistleblowers, these types of actions may occur. Read important information from the ANA regarding whistleblowing in the following box.

ANA Information Regarding Whistleblowing[3]

- If you identify an illegal or unethical practice, reserve judgment until you have adequate documentation to establish wrongdoing.
- Do not expect those who are engaged in unethical or illegal conduct to welcome your questions or concerns about this practice.
- Seek the counsel of someone you trust outside of the situation to provide you with an objective perspective.

3. American Nurses Association. *Things to know about whistle blowing*. https://www.nursingworld.org/practice-policy/workforce/things-to-know-about-whistle-blowing/

- Consult with your state nurses' association or legal counsel if possible before taking action to determine how best to document your concerns.
- Remember, you are not protected in a whistleblower situation from retaliation by your employer until you blow the whistle.
- Blowing the whistle means that you report your concern to the national and/or state agency responsible for regulation of the organization for which you work or, in the case of criminal activity, to law enforcement agencies as well.
- Private groups, such as The Joint Commission or the National Committee for Quality Assurance, do not confer protection. You must report to a state or national regulator.
- Although it is not required by every regulatory agency, it is a good rule of thumb to put your complaint in writing.
- Document all interactions related to the whistleblowing situation and keep copies for your personal file.
- Keep documentation and interactions objective.
- Remain calm and do not lose your temper, even if those who learn of your actions attempt to provoke you.
- Remember that blowing the whistle is a very serious matter. Do not blow the whistle frivolously. Make sure you have the facts straight before taking action.

10.6 Steps to Becoming an Advocate

To become a nursing advocate, identify causes, issues, or needs where YOU can exert influence.

Steps to becoming an advocate include the following[1]:

1. **Identify a problem that interests you:** Start by pinpointing a specific issue or area within nursing that you are passionate about. This could range from client safety and quality of care to workplace conditions and professional development opportunities.
2. **Research the subject and select an evidence-based intervention:** Conduct thorough research on the identified issue. Look for evidence-based practices and interventions that have been proven to address or mitigate the problem effectively. Gathering robust data will help you build a solid case for your advocacy efforts.
3. **Network with experts who are, or could be, involved in making the change:** Connect with professionals and experts who are either already involved in addressing the issue or who could play a crucial role in implementing changes. Building a network of like-minded individuals can provide support, resources, and additional perspectives.
4. **Work hard for change:** Advocacy requires dedication and persistence. Actively participate in efforts to bring about the desired change. This might include engaging in public speaking, writing articles or blogs, meeting with policymakers, or organizing community events to raise awareness.

Once you have identified a topic of interest, it's crucial to get involved in activities that can amplify your advocacy efforts:

1. Olson, K. (2020). *Influence through policy: Four steps you can take*. Nursing Centered. https://nursingcentered.sigmanursing.org/commentary/more-commentary/Vol42_2_influence-through-policy-four-steps-you-can-take

- **Committees:** Volunteer to participate in committees that review and develop practice policies within your health care institution.
- **Professional Nursing Organizations:** Become a member of state and national nursing organizations. These groups often provide valuable resources, including access to current legislative and policy initiatives, public policy agendas, and ways to get involved.
- **Research and Review:** Stay informed by researching best practices and reviewing the health policy agendas of elected officials. Understanding the current landscape will help you identify opportunities to influence policy and practice.

Nurses hold a powerful position to be effective advocates due to their frontline role in health care delivery. Their unique insights into client care, the work environment, and health care systems make them valuable voices in policy discussions. As the largest sector of the health care workforce, nurses have significant potential to influence decisions at every level.

Advocating for change can lead to improved quality of care, better client outcomes, and safe work environments. By pushing for evidence-based practices and policies, nurses can help ensure that clients receive the best possible care. Advocacy efforts focused on client safety and quality can directly impact client health and recovery. Additionally, nurses can advocate for better working conditions, which can lead to a safer and more supportive environment for all healthcare workers.

Imagine the impact if every nurse actively engaged in advocacy. The collective efforts could drive substantial improvements in health care delivery and policy, leading to positive changes across the profession.

Review information about a new professional nursing association called the Nurse Advocacy Association.

10.7 QSEN: Advocating for Patient Safety and Quality Care in Nursing Education

The Quality and Safety Education for Nurses (QSEN) project began advocating for safe, quality client care in 2005 by defining six competencies for nursing graduates. This initiative was created after a decade of review and investigation into the high number and high cost of medical errors in the United States. The goal of the QSEN initiative was to prepare future nurses with the knowledge, skills, and attitudes needed to improve the quality and safety of the health care system. Historically, nursing education focused on knowledge and skill acquisition, but did not address the attitudes and values of the nurse. The QSEN competencies are designed to train nursing students in prelicensure nursing programs. The six QSEN competencies, as shown in Figure 10.6,[1] are Patient-Centered Care, Teamwork and Collaboration, Evidence-Based Practice, Quality Improvement, Safety, and Informatics.[2]

> Read the QSEN Prelicensure Table of Competencies.

1. "QSEN Competencies.png" by Chippewa Valley Technical College is licensed under CC BY 4.0
2. QSEN. (n.d.). *About*. https://qsen.org/about-qsen/

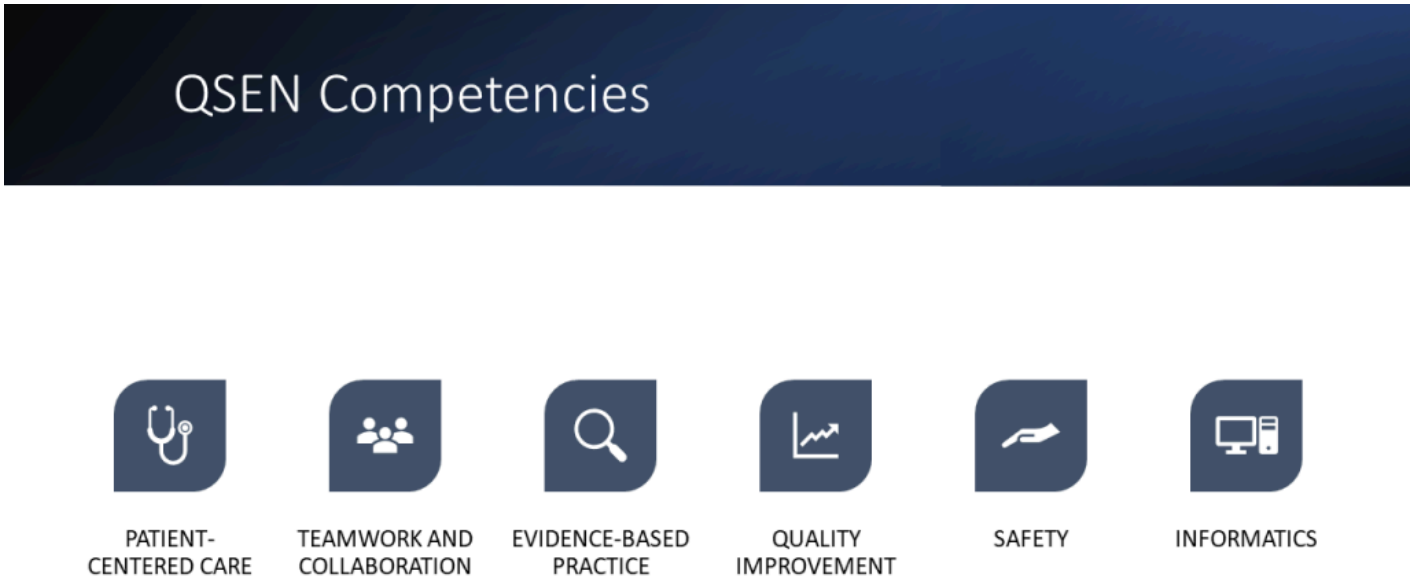


Figure 10.6 QSEN Competencies

Patient-Centered Care

The **Patient-Centered Care** QSEN competency advocates for the client as "the source of control and full partner in providing compassionate and coordinated care based on respect for client's preferences, values, and needs."[3] This competency encourages nurses to consider clients' cultural traditions and personal beliefs while providing compassionate care. Client-centered care also includes the family in the care team. The goal of client-centered care is to improve the individual's health outcomes. Integration of this competency has led to improved client satisfaction scores, reduced expenses, and a positive care environment.[4]

3. QSEN. (n.d.). *About*. https://qsen.org/about-qsen/

4. Roseman, D., Osborne-Stafsnes, J., Amy, C. H., Boslaugh, S., & Slate-Miller, K. (2013). Early lessons from four 'aligning forces for quality' communities bolster

Teamwork and Collaboration

The **Teamwork and Collaboration** QSEN competency focuses on functioning effectively within nursing and interprofessional teams and fostering open communication, mutual respect, and shared decision-making to achieve quality client care.[5] Effective communication has been proven to reduce errors and improve client safety.[6] The Joint Commission also includes improved communication as one of the National Patient Safety Goals, aligning with this QSEN competency. Collaboration requires information sharing across disciplines with respect for the knowledge, skills, and experience of each team member. Two examples of tools used to promote effective teamwork and collaboration are ISBARR and TeamSTEPPS®. Additionally, "principles of collaboration" have been established by the ANA.

ISBARR

Several communication tools have been developed to improve communication in various health care settings. ISBARR is an example of a well-established communication tool. As previously discussed in the "Collaboration Within the Interprofessional Team" chapter, **ISBARR** is a mnemonic for the components to include when communicating with other health care team members: **I**ntroduction, **S**ituation, **B**ackground, **A**ssessment, **R**equest/**R**ecommendations, and **R**epeat back.[7]

the case for patient-centered care. *Health Affairs, 32*(2), 232-241. https://doi.org/10.1377/hlthaff.2012.1085

5. QSEN. (n.d.). *About*. https://qsen.org/about-qsen/
6. Burgener, A. M. (2020). Enhancing communication to improve patient safety and to increase patient satisfaction. *The Health Care Manager, 39*(3), 128-132. https://doi.org/10.1097/hcm.0000000000000298
7. Enlow, M., Shanks, L., Guhde, J., & Perkins, M. (2010). Incorporating

TeamSTEPPS®

As previously discussed in the "Collaboration Within the Interprofessional Team" chapter, TeamSTEPPS® (Team Strategies and Tools to Enhance Performance and Patient Safety) is a well-established framework to improve client safety through effective communication in health care environments. It consists of four core competencies: communication, leadership, situation monitoring, and mutual support.

Principles of Collaboration

The American Nurses Association (ANA) and the American Organization of Nurse Executives (AONE) jointly created the "Principles of Collaboration" to guide nurses in creating, enhancing, and sustaining collaborative relationships. These principles include effective communication, authentic relationships, and a learning environment and culture. The principle of authentic relationships includes the following guidelines[8]:

- Be true to yourself – be sure your actions match your words and those around you are confident that what they see is what they get.
- Empower others to have ideas, to share those ideas, and to participate in projects that leverage or enact those ideas.
- Recognize and leverage each other's strengths.
- Be honest 100% of the time – with yourself and with others.

interprofessional communication skills (ISBARR) into an undergraduate nursing curriculum. *Nurse Educator, 35*(4), 176-180. https://doi.org/10.1097/nne.0b013e3181e339ac

8. American Nurses Association & American Organization of Nurses Executives. (n.d.). *ANA/AONE principles for collaborative relationships between clinical nurses and nurse managers*. https://www.nursingworld.org/~4af4f2/globalassets/docs/ana/ethics/principles-of-collaborative-relationships.pdf

- Respect others' personalities, needs, and wants.
- Ask for what you want but stay open to negotiating the difference.
- Assume good intent from others' words and actions, and assume they are doing their best.

> Read more about the "Principles of Collaboration" by the ANA and AONE.

Evidence-Based Practice

The **Evidence-Based Practice** QSEN competency focuses on integrating scientific evidence with clinical expertise and client/family preferences and values for delivery of optimal health care.[9] See Figure 10.7[10] for an illustration of Evidence-Based Practices (EBP). Read more about EPB in the "Quality and Evidence-Based Practice" chapter. Read examples of evidence-based improvements in the following box.

9. QSEN. (n.d.). *About*. https://qsen.org/about-qsen/
10. "Evidence-Based Practice.jpg" by Kim Ernstmeyer for Chippewa Valley Technical College is licensed under CC BY 4.0



Figure 10.7 Evidence-Based Practice

Read these examples of evidence-based practice improvements:

- Intravenous catheter sizes PDF
- Oxygen administration for COPD patients
- Recognizing alarm fatigue

Quality Improvement

The **Quality Improvement** QSEN competency focuses on 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.[11] The goal of this competency is to improve processes,

11. QSEN. (n.d.). *About*. https://qsen.org/about-qsen/

policies, and clinical decisions to improve client outcomes and system performance. As the pool of nursing literature grows and nursing practices have been updated to reflect current evidence, health care organizations have seen improvements in quality, safety, and experienced cost savings.[12] Read more about the quality improvement processes in the "Quality and Evidence-Based Practice" chapter.

Safety

The **Safety** QSEN competency focuses on minimizing "risk of harm to patients and providers through both system effectiveness and individual performance."[13] Although safety is embedded in all of the QSEN competencies, this competency specifically advocates for preventing client harm. Despite the health care industry's continued focus on process improvement and improving client outcomes, errors continue to occur, and nurses are often involved in these events as frontline caregivers. Safe nursing practice starts with an awareness of the potential risks for client harm in every situation.

Several initiatives have been adopted to reduce risk for client harm, such as double-checking high-risk medications and verifying a client's name and date of birth prior to every intervention. However, client safety is compromised when there are gaps in quality measures such as inadequate staff training, broken equipment, or an organizational culture that doesn't support best practices.

The "Safety" competency is best addressed by organizations establishing a safety culture where every worker commits to keeping client safety at the center of decision-making. An organization that has a culture of safety

12. Cullen, L., Titler, M. G., & Rempel, G. (2011). An advanced educational program promoting evidence-based practice. *Western Journal of Nursing Research, 33*(3), 345-364. https://doi.org/10.1177/0193945910379218

13. QSEN. (n.d.). *About*. https://qsen.org/about-qsen/

encourages reporting of unusual incidents, process failures, or other issues that could cause client harm, allowing the organization to investigate the event and take action to prevent the event from occurring in the future. Improvements are made as a result of a culture that questions attitudes, actions, and decisions in client care and recognizes threats to safety. Read more about safety culture in the "Legal Implications" chapter.

Informatics

The **Informatics** QSEN competency focuses on using information and technology to communicate, manage knowledge, mitigate error, and support decision-making.[14] Health care is filled with various technologies used to promote a safe care environment, such as electronic medical records (EMRs), bedside medication administration devices, smart IV pumps, and medication distribution systems. These technologies provide safeguards and reminders to help prevent client harm, but the nurse must be knowledgeable in using technology, as well as understand how information obtained from technologies is used to improve client outcomes. As information related to technology continues to evolve, it is the responsibility of every nurse to participate in continued professional development related to informatics.

14. QSEN. (n.d.). *About*. https://qsen.org/about-qsen/

10.8 Spotlight Application

Case Study

An 85-year-old woman was admitted with sudden onset of dyspnea, pleuritic chest pain, and right upper arm edema. She had a peripherally inserted central catheter (PICC) placed three weeks previously for treatment of osteomyelitis of the left hand. A caretaker had been infusing her antibiotics and managing her PICC with the oversight of a home care nurse. A chest computerized tomography scan confirmed the presence of a pulmonary embolism. She was admitted to the inpatient floor at change of shift, and orders were received for a weight-based heparin bolus and infusion. The bolus was administered, and the infusion was initiated. During handoff report to the next shift, the pump alarm sounded. In responding to the alarm, the oncoming nurse discovered that the entire bag of heparin (25,000 units) had infused in less than 30 minutes. She discovered the rate on the pump was set by the previous nurse at 600 mL/hour rather than the weight-adjusted 600 units/hour.

The oncoming nurse who discovered the heparin error immediately disconnected the infusion, assessed the client for signs of bleeding, and notified the physician of the error. Appropriate precautions were initiated and an incident report was submitted. Subsequently, an investigation was conducted by the unit supervisor and the risk manager by interviewing involved staff. They found that the client's admitting nurse, who administered the heparin bolus and infusion, was a traveling nurse who had been in the organization for three weeks and had been floated to the telemetry unit for the first time. While the traveling nurse had been trained on an orthopedic unit, she had not initiated a heparin infusion at this facility. The facility used an infusion pump that included a drug library with medication-specific infusion limits for client safety. The nurse had been trained to use the infusion pump drug library in a brief orientation, but she had witnessed several nurses bypass this safety measure. In addition, although she had her heparin bolus and infusion calculations double-checked by another nurse, she was not aware that this double-check should include a review of pump settings.

Finally, because the change of shift handoff report was hurried, it did not include a bedside report to review infusions and client status with the oncoming nurse. What appeared to be a serious individual error was, in fact, a complex series of failures in the facility's safety culture that placed a nurse in the very difficult position of making an error that placed a client at risk of harm. Fortunately, no significant bleeding events occurred as a result of the error.[1]

Reflective Questions

1. Create a list of safety failures in this example and categorize them based on the QSEN competencies.
2. Outline communication tools and best practices that could have prevented this error from occurring.

1. Sherwood, G., & Nickel, B. (2017). Integrating quality and safety competencies to improve outcomes: Application in infusion therapy practice. *Journal of Infusion Nursing, 40*(2), 116-122. https://doi.org/10.1097/NAN.0000000000000210

10.9 Learning Activities

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nursingmpc/?p=716#h5p-20

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nursingmpc/?p=716#h5p-21

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nursingmpc/?p=716#h5p-22

Test your knowledge using this NCLEX Next Generation-style Case Study. You may reset

- and resubmit your answers to this question an unlimited number of times.[1]

1. “Chapter 10, Assignment 1” by Travis Christman for OpenRN is licensed under CC BY-NC 4.0

X Glossary

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.

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

Evidence-based practice: Integrating scientific evidence with clinical expertise and client/family preferences and values for delivery of optimal health care.[1]

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

Informatics: Using information and technology to communicate, manage knowledge, mitigate error, and support decision-making.[2]

ISBARR: A mnemonic for the components to include when communicating with another health care team member: Introduction, Situation, Background, Assessment, Request/Recommendations, and Repeat back.

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

Patient-centered care: The client is the source of control and full partner in providing compassionate and coordinated care based on respect for client's preferences, values, and needs.[3]

1. QSEN. (n.d.). *About.* https://qsen.org/about-qsen/
2. QSEN. (n.d.). *About.* https://qsen.org/about-qsen/
3. QSEN. (n.d.). *About.* https://qsen.org/about-qsen/

Quality improvement: 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.[4]

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

Social Determinants of Health (SDOH): The conditions in the environments where people live, learn, work, and play that affect a wide range of health, functioning, and quality of life outcomes and risks.

TeamSTEPPS® (Team Strategies and Tools to Enhance Performance and Patient Safety): An evidence-based framework to improve client safety through effective communication in health care environments consisting of four core competencies: communication, leadership, situation monitoring, and mutual support.

Teamwork and collaboration: Functioning effectively within nursing and interprofessional teams, fostering open communication, mutual respect, and shared decision-making to achieve quality client care.[5]

Whistleblower: A person who exposes any kind of information or activity that is deemed illegal, unethical, or not correct within an organization.

4. QSEN. (n.d.). *About.* https://qsen.org/about-qsen/

5. QSEN. (n.d.). *About.* https://qsen.org/about-qsen/

PART XI

CHAPTER 11 - PREPARATION FOR THE RN ROLE

11.1 Preparation for the RN Role Introduction

Learning Objectives

- Develop a current professional resume or portfolio
- Identify steps for preparing for the NCLEX-RN examination
- Identify actions for obtaining nursing credential
- Identify strategies for successful nursing interviews
- Develop goals for lifelong learning and professional development

Preparing to enter the workforce as a registered nurse (RN) can be a challenging but exciting time. Being aware of available resources to help navigate this process will decrease stress and make the process more manageable. This chapter will discuss how to prepare for the NCLEX-RN examination, obtain a nursing license, create a resume and portfolio, effectively participate in an interview, transition into the RN role, and become a lifelong learner.

11.2 Preparing for the NCLEX

The National Council Licensure Examination for Registered Nurses (**NCLEX-RN**) is the exam that nursing graduates must pass successfully to obtain their nursing license and become a registered nurse. The purpose of the NCLEX is to evaluate if a nursing graduate (i.e., candidate) is competent to provide safe, competent, entry-level nursing care. The NCLEX-RN is developed by the National Council of State Board of Nursing (NCSBN), an independent, nonprofit organization composed of the 50 state boards of nursing and other regulatory agencies.[1]

The NCLEX-RN is a pass/fail examination administered on a computer using computer adaptive testing (CAT). CAT means that every time a candidate answers a test item, the computer reestimates their ability based on all their previous answers and the difficulty of those items. The computer then selects the next item based on an estimated 50% chance of the candidate answering it correctly. In this manner, the next item is not too easy nor too difficult, and a candidate's true ability level is determined. Each item is perceived by the candidate as challenging because it is targeted to their ability. With each item answered, the computer's estimate of the candidate's ability becomes more precise.

The computer stops providing items when it is 95% certain that the candidate's ability is clearly above or clearly below the passing standard, the candidate has received the maximum number of questions, or the candidate has run out of time without demonstrating a competence level to pass. Testing accommodations may be provided for eligible candidates with the authorization of the candidate's State Board of Nursing (SBON).[2,3]

1. NCSBN. (2025). *NCLEX*. https://www.ncsbn.org/nclex.htm
2. NCSBN. (2025). *NCLEX*. https://www.ncsbn.org/nclex.htm
3. NCSBN Examinations. (2024). *2024 NCLEX examination candidate bulletin*.

See an image of a simulated graduate taking the NCLEX in Figure 11.1.[4]



Figure 11.1 Simulated Graduate Taking the NCLEX

Read more about the NCLEX at https://www.ncsbn.org/nclex.htm.

Watch a video about how the NCLEX uses computer assistive technology (CAT) at https://www.ncsbn.org/356.htm.

https://www.nclex.com/files/2024_NCLEX_Candidate_Bulletin_English_FINAL.pdf

4. "Woman_with_computer.jpg" by Cumminsr at English Wikipedia is licensed under CC BY-SA 3.0

Registering to Take the NCLEX

Before you can register to take the NCLEX, you will need an Authorization to Test (ATT). To receive an ATT, complete the following steps[5]:

- Apply for a nurse license from your State Board of Nursing (SBON) or other nursing regulatory body
- Register with Pearson VUE and pay the exam fee
- Wait to receive your ATT from Pearson Vue
- Schedule your exam with Pearson VUE

Be sure to start this process well in advance of your target date for taking the NCLEX.

Read specific instructions regarding registering and taking the NCLEX-RN by downloading the most current *NCLEX-Candidate Bulletin* from the NCSBN. The content includes the following:

- Registering for the exam
- Scheduling the exam
- Understanding test site rules and regulations
- Preparing for the day of the exam

> Download the most current *NCLEX-Candidate Bulletin* from https://www.ncsbn.org/nclex.htm.

Next Generation NCLEX

A new edition of NCLEX was released in 2023 with “Next Generation”

5. NCSBN. (2025). *NCLEX*. https://www.ncsbn.org/nclex.htm

questions.The Next Generation NCLEX (Next Gen) uses evolving case studies and new types of test questions based on a new NCSBN Clinical Judgment Measurement Model (NCJMM) that assesses how well the candidate can think critically and use clinical judgment when providing nursing care. The NCJMM assess the candidate's ability to recognize cues, analyze cues, prioritize hypotheses, generate solutions, take actions, and evaluate outcomes.[6]

Five new Next Generation test item types are called extended multiple response, extended drag and drop, cloze (drop-down), extended hot spot (highlighting), and matrix-grid[7]:

- **Extended Multiple Response:** Extended Multiple Response items allow candidates to select one or more answer options at a time. This item type is similar to the current NCLEX multiple response item but has more options and uses partial credit scoring.
- **Extended Drag and Drop:** Extended Drag and Drop items allow candidates to move or place response options into answer spaces. This item type is like the current NCLEX ordered response items but not all of the response options may be required to answer the item. In some items, there may be more response options than answer spaces.
- **Cloze (Drop – Down):** Cloze (Drop – Down) items allow candidates to select one option from a drop-down list. There can be more than one drop-down list in a cloze item. These drop-down lists can be used as words or phrases within a sentence or within tables and charts.
- **Enhanced Hot Spot (Highlighting):** Enhanced Hot Spot items allow candidates to select their answer by highlighting predefined words or phrases. Candidates can select and deselect the highlighted parts by clicking on the words or phrases. These types of items allow an individual to read a portion of a client medical record (e.g., a nursing note, medical

6. NCSBN. (2025). *NCLEX*. https://www.ncsbn.org/nclex.htm

7. NCSBN. (2025). *NCLEX*. https://www.ncsbn.org/nclex.htm

history, lab values, medication record, etc.), and then select the words or phrases that answer the item.

- **Matrix/Grid:** Matrix/Grid items allow the candidate to select one or more answer options for each row and/or column. This item type can be useful in measuring multiple aspects of the clinical scenario with a single item. In the example below, each of the eight rows will need to have one of the three answer choices selected.

View a NCSBN video on Next Generation test items.

Participate in an NCLEX tutorial at https://www.ncsbn.org/nclex-tutorial.htm.

Preparing for the Examination

Since the first day of nursing school, you have been working towards successfully passing the NCLEX-RN. After you graduate, it is important to implement strategies for success for taking the NCLEX, such as reviewing the NCLEX-RN Test Plan, setting up a dedicated review schedule based on your test date, and reviewing material you learned throughout nursing school.[8]

NCLEX Test Plan

The **NCLEX-RN Test Plan** provides a concise summary of the content and scope of the exam and serves as an excellent guide for preparation. NCLEX-

8. NCSBN. (2025). *NCLEX*. https://www.ncsbn.org/nclex.htm

RN test plans are updated every three years based on surveys of newly licensed registered nurses to ensure the NCLEX questions reflect fair, comprehensive, current, and entry-level nursing competency.[9]

The NCLEX Test Plan categorizes test questions based on categories and subcategories referred to as "Client Needs"[10]:

- Safe and Effective Care Environment
  - Management of Care
  - Safety and Infection Control
- Health Promotion and Maintenance
- Psychosocial Integrity
- Physiological Integrity
  - Basic Care and Comfort
  - Pharmacological and Parenteral Therapies
  - Reduction of Risk Potential
  - Physiological Adaptation

In addition, the following concepts are applied throughout the client needs categories[11]:

- Nursing Process
- Caring
- Communication and Documentation
- Teaching and Learning
- Culture and Spirituality

9. NCSBN. (2025). NCLEX. https://www.ncsbn.org/nclex.htm
10. NCSBN. (2025). *NCLEX*. https://www.ncsbn.org/nclex.htm
11. NCSBN. (2025). *NCLEX*. https://www.ncsbn.org/nclex.htm

- Download the current NCLEX-RN Test Plan from https://www.ncsbn.org/testplans.htm.

Review Schedule

Many students find it helpful to create and follow a study calendar with topics to review based on the NCLEX Test Plan.

Reviewing Material

Some graduates prefer to attend an NCLEX review course to prepare for the examination whereas others prefer to review their notes from nursing school on their own. Be sure to review the NCLEX Candidate Rules before the day of the examination.[12,13]

Day of the Examination

On the day of the examination, it is normal to experience some anxiety. However, it is important to use techniques to manage anxiety, so it does not impact your ability to think through and answer the test questions. Use positive self-talk and remind yourself that you have been preparing for this examination since the first day of nursing school. Read additional tips for the day of the NCLEX and tips for testing in the following boxes.

12. NCSBN. (2025). *NCLEX*. https://www.ncsbn.org/nclex.htm
13. NCSBN Examinations. (2024). *2024 NCLEX examination candidate bulletin*. https://www.nclex.com/files/2024_NCLEX_Candidate_Bulletin_English_FINAL.pdf

Tips for the Day of the NCLEX[14]

- Locate the test center prior to the day of the exam, if possible.
- Get plenty of sleep the night before the exam.
- Eat prior to the examination.
- Dress comfortably.
- Bring your ID.
- Arrive early (30 minutes).
- All personal items must be placed in a sealable, plastic bag that is provided and placed in lockable storage. This includes electronic devices such as cell phones, tablets, smart watches, or other electronic devices.

Tips for Testing[15]

- Perform relaxation breathing to stay calm and focused (take a few deep breaths in and out and remind yourself you are ready).
- Set your pace as you proceed through the questions based on the time limit for the exam.
- There are two optional breaks during the exam (the first break occurs two hours into testing, and the second break occurs after 3.5 hours of testing).
- Take time to analyze each question carefully—once you submit an answer, you can't return to that question.
- The exam ends with a short, computerized survey. Afterwards, raise your hand and wait for the testing administrator to dismiss you. The sealed bag that was placed in locked storage will be inspected.

After the Examination

If your State Board of Nursing (SBON) or nursing regulatory body (NRB) participates in the "Quick Results Service," you can receive your "unofficial"

14. NCSBN. (2025). NCLEX. https://www.ncsbn.org/nclex.htm

15. NCSBN. (2025). NCLEX. https://www.ncsbn.org/nclex.htm

results two business days after the exam if you pay for this service. Official results are sent to you approximately six weeks after the exam.[16]

If you didn't pass the exam, you'll receive an NCLEX Candidate Performance Report (CPR). The CPR is an individualized document that shows how a candidate performed in each of the test plan content areas. Graduates who fail the exam can use the CPR as a guide to prepare them to retake the exam.[17]

If you need to retake the exam, you will need to wait a minimum of 45 days before you can retake the NCLEX per NCSBN policy. This length of time is determined by your SBON (or NRB) and will be reflected in your new ATT's validity dates. Read the steps for retaking the NCLEX in the following box.

Steps for Retaking the NCLEX

- Contact your State Board of Nursing (SBON) or nursing regulatory body (NRB) and notify them that you plan to retake the exam.
- Determine what fees or materials you need to submit to the SBON or NRB.
- Reregister with Pearson VUE and pay the fee.
- Wait to receive your new ATT.
- Schedule your new exam.
- Review your CPR and set up a review plan.

16. NCSBN. (2025). NCLEX. https://www.ncsbn.org/nclex.htm

17. NCSBN. (2025). NCLEX. https://www.ncsbn.org/nclex.htm

11.3 Obtaining Your Nursing License

Licensure is the process by which a State Board of Nursing (SBON) grants permission to an individual to engage in nursing practice after verifying the applicant has attained the competency necessary to perform the scope of practice of a registered nurse (RN).[1] The SBON verifies these three components:

- Verification of graduation from an approved prelicensure RN nursing education program
- Verification of successful completion of NCLEX-RN examination
- A criminal background check (in some states)[2]

In the United States there are three common types of prelicensure educational programs that prepare a student to become an RN, including a two-year associate degree of nursing (ADN), a hospital-based diploma program, or a four-year baccalaureate degree (BSN). Some universities offer an "Entry Level Master of Science in Nursing Track" for non-nurses holding a baccalaureate or master's degree in another field who wish to become a nurse. All graduates must pass the same NCLEX-RN to obtain their RN license from their SBON (or other nursing regulatory body).

Requirements for licensure renewal vary from state to state. Some states require continued education credits (CEUs), along with the payment of fees. In Wisconsin the nursing license is renewed every two years. See Figure 11.2[3] for an image of a simulated nursing license.

1. NCSBN. (2025). NCLEX. https://www.ncsbn.org/nclex.htm
2. NCSBN. (2025). NCLEX. https://www.ncsbn.org/nclex.htm
3. "3277658479_86d3d7d61c_o.jpg" by Vernon Dutton is licensed under CC BY-NC-SA 2.0

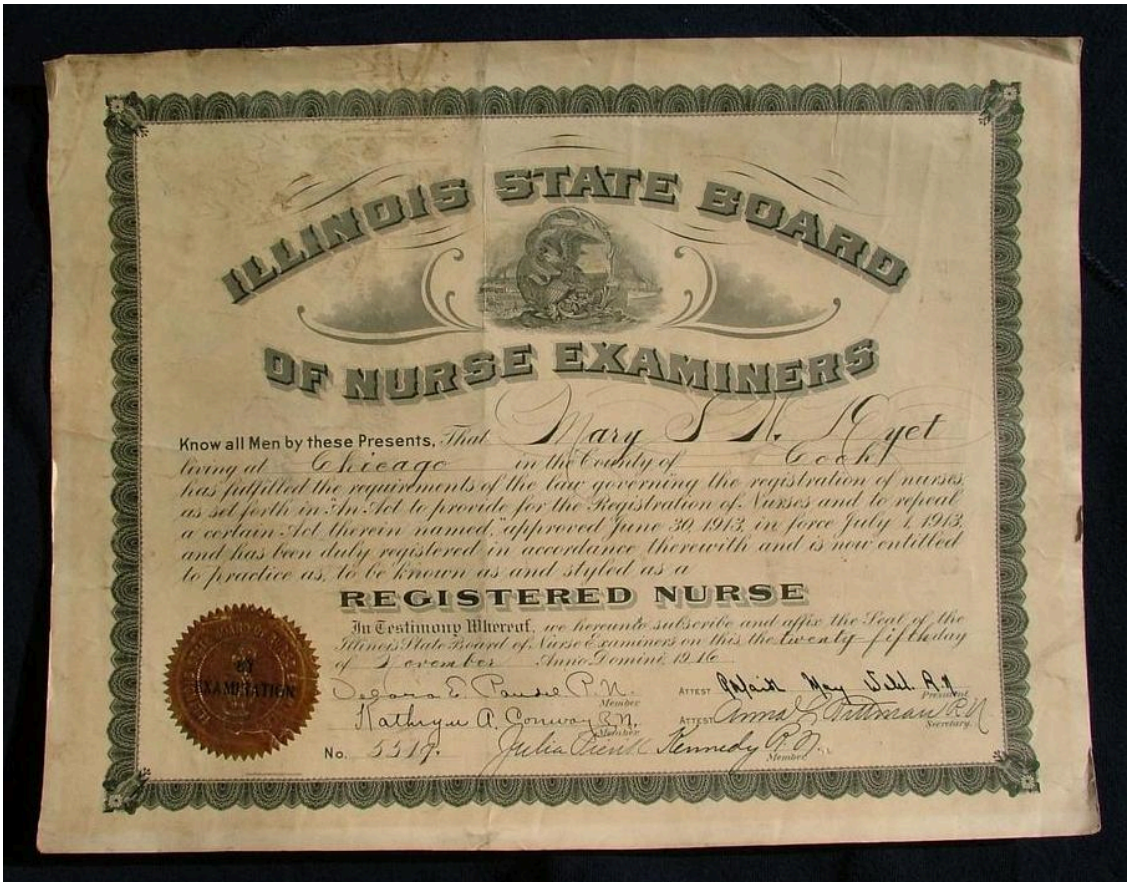


Figure 11.2 Simulated Nursing License

- Use this map for contact information for the State Boards of Nursing.
- Read more details on obtaining a Wisconsin RN license at https://dsps.wi.gov/Pages/Professions/RN/Default.aspx.

Nurse Licensure Compact

When applying for your nursing license from your State Board of Nursing (SBON), you may also be eligible to apply for a multistate license. The **Nurse Licensure Compact** (NLC) allows nurses to practice in other NLC states with their original state's nursing license without having to obtain additional licenses, contingent upon remaining a resident of that state. Currently, 38

states have enacted the NLC. Read more information about the NLC using the information in the following box.

- View the current Nurse Licensure Compact Map.
- Read this algorithm on how to Navigate the Nurse Licensure Compact.
- Read more information about the Nurse Licensure Compact Rules.

Watch a video for nursing students on the Nurse Licensure Compact.

Temporary Permit

In some states before taking the NCLEX, an applicant may apply to receive a temporary permit from their State Board of Nursing (SBON). A **temporary permit** allows the applicant to practice practical nursing under the direct supervision of a registered nurse until the RN license is granted. A temporary permit is typically valid for a period of three months or until the holder receives failing NCLEX results, whichever is shorter.

- Read about the temporary permit available in Wisconsin.

11.4 Applying for a Nursing Position

Many students begin applying for their first nursing position before they graduate or take the NCLEX-RN. Read tips for employment in the following box.

Tips for Employment

- Reflect on previous clinical rotations and the experience. It is helpful to apply at agencies where you have had a positive learning experience.
- Obtain employment at a health care agency as a nursing assistant, licensed practical/vocational nurse (LPN/VN), or intern prior to graduation. This allows you to experience the workplace culture. Intern and extern roles allow the nursing student to perform nursing skills under the supervision of an RN, often with a temporary permit obtained from their State Board of Nursing (SBON). After receiving your RN license, it is often an easier transition into the nursing role. Working at the facility prior to graduation also increases familiarity with the environment, electronic health record, and health care team.

During your job-search process, it is helpful to begin by reviewing Medicare's quality ratings of health care agencies and providers. The "overall star rating" is based on how well the agency performs on various quality indicators and client satisfaction surveys.

- Review Medicare ratings of hospitals, nursing homes, home health agencies, and providers at www.medicare.gov/care-compare.

When applying for a job position, a resume and/or portfolio is typically included as part of the application process.

Resume

A **resume** is a document that highlights one's background, education, skills,

and accomplishments to potential employers. There are many types of resume formats, and some individuals elect to use online services to create a professional resume.

A resume typically includes the following components:

- Personal contact information
- Professional objective statement/Goals
- Education
- Work experience
- Awards and achievements
- Community service
- Languages, hobbies, volunteer experiences (optional)

When creating a resume, it is helpful to highlight skills and experience that separate you from the other candidates applying for the position. It is also helpful to tailor your resume to the skills and experience expressed in the job description.

- Read more details about what to put in a resume and nursing resumes and cover letters.
- View a sample resume.
- View a sample Online Resume Service.

Portfolio

A **portfolio** is a compilation of materials showcasing examples of previous work demonstrating one's skills, qualifications, education, training, and

experience. They can be submitted in electronic or paper form. See Figure 11.3[1] for an image of a sample electronic portfolio.

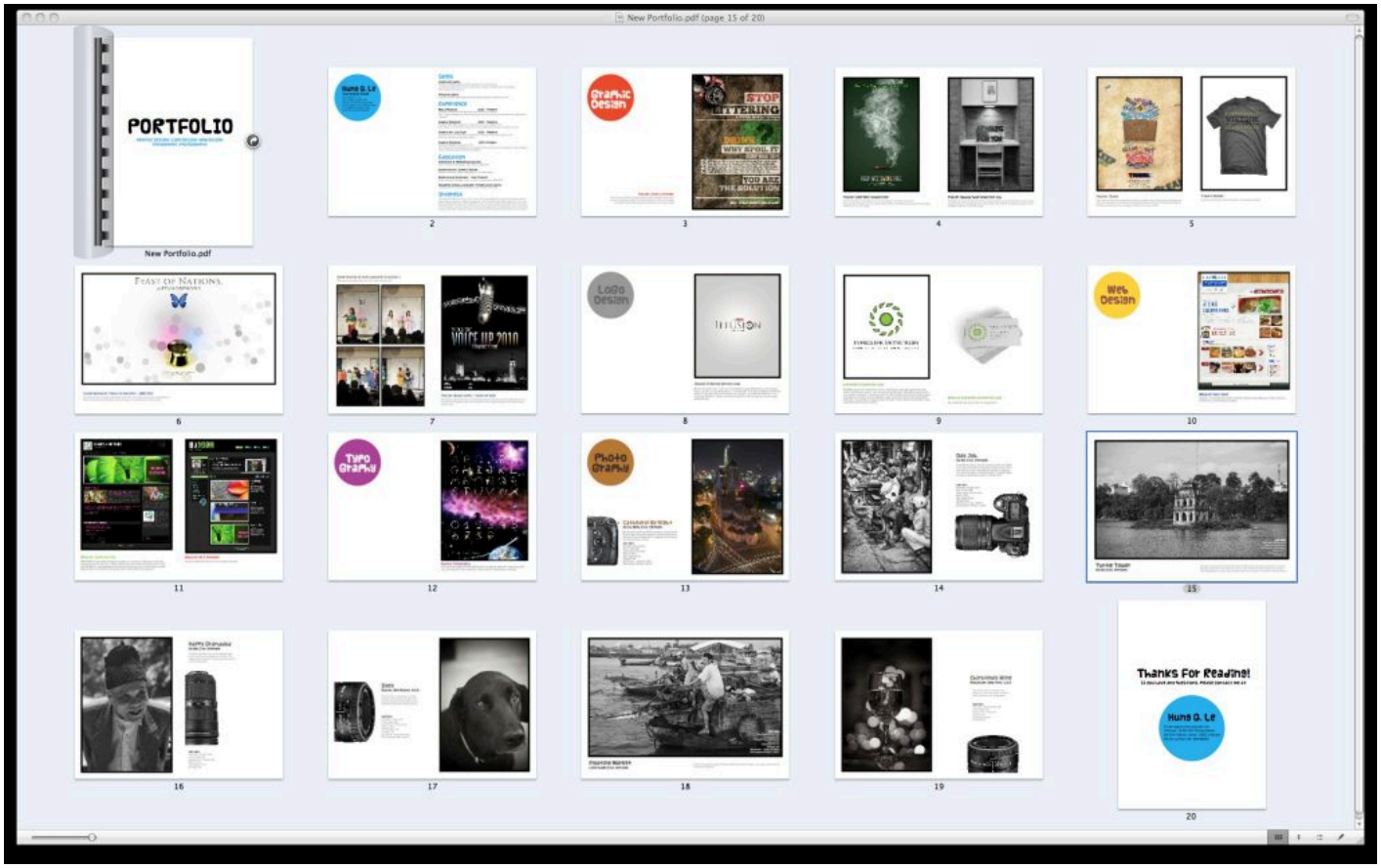


Figure 11.3 Sample Electronic Portfolio

Some schools of nursing require portfolios to be completed throughout the program. These portfolios are a representation of work demonstrating the student's accomplishments.

Portfolios typically include the following:

- Personal contact information
- Resume
- Professional goals
- Skilled work with examples (e.g., a nursing care plan, process recording, teaching plan, etc.)

1. "4805383850_7385e60b6c_k.jpg" by Hung Le is licensed under CC BY 2.0

- Accomplishments (e.g., dean's list)
- Degrees
- Certifications (e.g., CPR)
- Professional memberships (e.g., Student Nurse Association)
- Community service activities
- References (if requested)

> - Read more about what to include in a portfolio.
> - Visit an online portfolio service.

Interviewing

After applying for a position and submitting your resume and/or portfolio, you may be contacted to set up an interview. When you're interviewing for an RN position, you will be asked about your skills, experience, and your education. Some questions may be basic, such as, "Why did you become a nurse?" Other questions may be more difficult to answer, such as "Explain your strengths and weaknesses as an RN." See Figure 11.4[2] for a simulated interview.

2. "24835247668_0828e986ad_k.jpg" by Amtec Photos is licensed under CC BY-SA 2.0



Figure 11.4 Simulated Interview

Interviewing for a new position can cause anxiety because you are required to answer questions and provide examples. A strategy to make the interview process easier and reduce anxiety is to prepare answers for commonly asked questions prior to the interview. Completing this task will help you prepare and increase your confidence. See common interview questions in the following box. It is helpful to tailor your answers to the skills and experience provided in the position description of the job you are seeking.

Common Questions During an Interview

- Tell me about yourself.
- Why did you become an RN?
- What is your educational background?
- What are your future goals?
- What are your strengths?
- What are your weaknesses?
- Give an example of how you were a good team player.
- Tell me about a time you cared for a challenging client and how you handled the situation.

Prior to your interview, research the organization's website. Be aware of their mission and vision statements and any "current events" in the news. Interviewers are impressed when an applicant has taken the time to learn about the organization and demonstrates interest.

Interviews may take place face-to-face, virtually on a computer, or over the phone. If you are interviewing face-to-face or virtually, dress for success in professional attire. If interviewing virtually, be sure to decrease distractions at home by turning off your phone and conducting the interview in a quiet space. Establish good eye contact with the interviewer and speak in a confident manner. Remember, this is the time to "sell your nursing self," so highlight your achievements and what you are proud of accomplishing. See additional tips for interviews in the following box.

Tips for Interviews

- Dress in business casual attire.
- Arrive ten minutes early for the interview.
- Bring copies of your resume or portfolio.
- Silence your cell phone.
- Do not chew gum.
- Answer all questions honestly and thoroughly. Provide examples when feasible.
- Ask questions.
- At the end, thank the interviewer and ask when you will be notified if you are offered the position.

The interview process is also an opportunity for you to determine if this position and agency is a good fit for you. Remember that it is important to select an agency that has good ratings for providing safe client care and client satisfaction. It is not worth taking a position that may place your nursing license at risk. Ask questions of the interviewer to clarify your understanding of the job position and expectations, agency policies, and workplace culture. Suggested interview questions are listed in the following box.

Questions for Interviewer

- How long is the orientation process?
- How long will I have access to a mentor?
- Do you have a nurse residency program?
- What system do you use for the electronic health record?
- What is the weekend rotation requirement?
- What are the holiday requirements?
- What are the staffing ratios?
- What are your policies regarding “mandatory overtime” and “off with benefits”?
- How long are the shifts?
- What is your policy for tuition reimbursement?
- What is the salary range?
- How does this organization handle error reporting?
- How has this organization adopted The Joint Commission’s Culture of Safety, such as the Just Culture model?
- Do you have an ethics committee or other resources for nurses?

11.5 Transitioning to the RN Role

Reality Shock

As a new graduate transitions into the role of being a registered nurse (RN), it is very common to experience something called "reality shock." Although Kramer's "Reality Shock" theory is several decades old, it continues to apply to new nurses transitioning to their new role through a process of learning and growing. Kramer's Reality Shock theory characterizes four phases of transitioning into a new role referred to as the honeymoon, shock, recovery, and resolution phases[1]:

- **Honeymoon phase:** The first phase occurs when the newly graduated RN is excited to join the nursing profession and it is everything they imagined. During this phase, the new nurse is typically paired up with a preceptor RN to orient them to the new role.
- **Shock phase:** The second phase is when the new RN is the most vulnerable. They are moved off orientation and independently perform tasks without the guidance of their preceptor. The RN role is often more difficult than the new nurse previously imagined. The new RN realizes their expectations associated with the nursing role may be inconsistent with the actual responsibilities. During this phase, negative feelings regarding their new profession may arise, and the new RN is at greatest risk for leaving the unit or quitting.
- **Recovery phase:** The third phase is when new RNs begin to have positive feelings towards their profession again. During this phase, the new RN is able to reflect on their experiences and develop a clear understanding of their responsibilities and role expectations. The novice RN typically experiences decreased tension and anxiety and begins to assist other RNs as needed.
- **Resolution phase:** The fourth and final phase is usually at the end of the first year of the new position. The new RN can visualize how the role

1. Kramer, M. (1974). *Reality shock: Why nurses leave nursing*. C. V. Mosby Co.

contributes to the profession, and work expectations are easily met.

Transitioning Into Practice

Over the years, the National Council of State Boards of Nursing (NCSBN) has researched the complex issue of retaining new nursing graduates and found the inability of new nurses to properly transition into practice can have grave consequences. New nurses care for sicker clients in increasingly complex health settings and feel increased stress levels. As a result, new nurses are involved in more client safety and practice errors than experienced nurses. It has been reported by the NCSBN that within the first year of employment, 25% of novice RNs leave their nursing positions.[2]

There are several potential strategies for helping new nurses transition into practice. The first step of the transition is being aware of "reality shock" and the phases of the transition process. A thorough orientation process with an experienced preceptor is a traditional strategy for transitioning into a new nursing position. A newer strategy being implemented in some agencies is a nurse residency program.

Orientation may last anywhere from one to four months, but can be longer depending on the specialty (e.g., Intensive Care or Labor and Delivery). Orientation is based on the new nurse's demonstration and completion of competencies. During this time, the novice RN will work with a preceptor to experience all aspects of the role.

Preceptors are experienced and competent RNs who serve as a role model and a resource to a newly hired nurse. Preceptors have the knowledge, skills, and the ability to coach the new RN into the nursing role and answer their questions. The preceptor also evaluates a new hire's performance and provides feedback for improvement.

2. NCSBN. (n.d.). *Transition to practice: Why transition to practice (TTP)?* http://www.ncsbn.org/transition-to-practice.htm

Nurse residency programs provide additional professional development support for all newly licensed nurses. Nurse residency programs vary from institution to institution, but many start around the time the new graduate ends their orientation with a preceptor and continue to provide routine support throughout the year. Residency programs are structured to provide a variety of learning opportunities, including nursing skill development, peer networking, and mentorship. The goal of nurse residency programs is to provide organizational support for newly licensed nurses during the critical phase of transitioning from student to professional nurse.[3] See Figure 11.5[4] for an image of new nurses participating in a nurse residency program.



Figure 11.5 Nurse Residency Program

Benner's Novice to Expert Theory

As a nursing graduate transitions into a new nursing role, a well-known

3. Ackerson, K., & Stiles, K. A. (2018). Value of nurse residency programs in retaining new graduate nurses and their potential effect on the nursing shortage. *The Journal of Continuing Education in Nursing, 49*(6). https://doi.org/10.3928/00220124-20180517-09

4. "1637163589.jpg" by Monkey Business Images is used under license from Shutterstock.com

theory called "**Benner's Novice to Expert Theory**" explains how new hires develop skills and a holistic understanding of client care over time, resulting from a combination of a strong educational foundation and thorough clinical experiences. See Figure 11.6[5] for an illustration of Benner's Novice to Expert Theory. Benner's theory identifies five levels of nursing experience: novice, advanced beginner, competent, proficient, and expert.[6]

- A **novice** is a beginner with no clinical experience. They are taught general rules to help perform tasks, and their rule-governed behavior is limited and inflexible. In other words, they are told what to do and simply follow instructions.
- An **advanced beginner** shows acceptable performance and has gained prior experience in actual nursing situations. This experience helps the nurse recognize recurring patterns of client symptoms and behaviors. An advanced beginner begins to formulate strategies, based on their previous experiences, to guide actions.
- A **competent nurse** generally has two or three years' experience on the job in the same type of position that has similar day-to-day situations. Competent nurses become aware of long-term goals and gain perspective from planning their own actions. This helps them achieve greater efficiency and organization.
- A **proficient nurse** perceives and understands situations as whole parts, so they have a holistic understanding of nursing that improves their decision-making. Proficient nurses have learned what to expect in various client situations and how to modify plans as needed.
- **Expert nurses** no longer rely on principles, rules, or guidelines to connect situations and determine actions. They have a deeper background of

5. "Novice to Expert.png" by Meredith Pomietlo for Chippewa Valley Technical College is licensed under CC BY 4.0

6. Nursing Theory. (2020). *Dr. Patricia Benner novice to expert – nursing theorist.* https://nursing-theory.org/nursing-theorists/Patricia-Benner.php

experience and an intuitive grasp of clinical situations. Their performances are fluid, flexible, and highly proficient.[7]

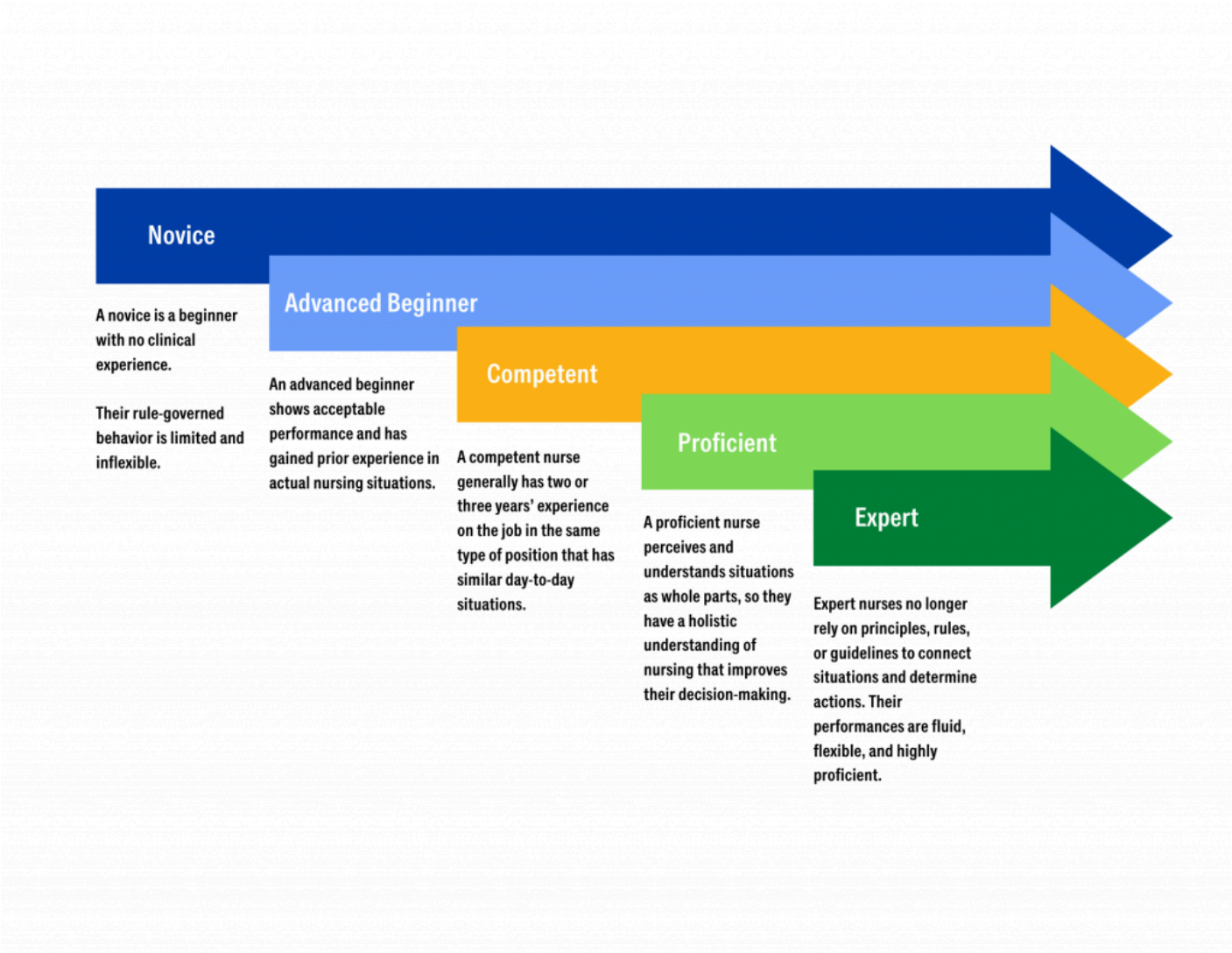


Figure 11.6 Novice to Expert Theory

Mentorship

The value of mentorship in the nursing profession is immense, impacting both the personal and professional development of nurses and the overall quality of client care. Mentorship involves experienced nurses providing guidance, support, and knowledge to less experienced or new nurses,

7. Nursing Theory. (2020). *Dr. Patricia Benner novice to expert – nursing theorist.* https://nursing-theory.org/nursing-theorists/Patricia-Benner.php

fostering their growth and integration into the profession. This relationship is essential for building a competent, confident, and resilient nursing workforce.[8]

One of the primary benefits of mentorship is the enhancement of clinical skills and knowledge. Experienced mentors share their expertise, clinical insights, and practical tips with mentees, helping them develop critical thinking and problem-solving abilities. This hands-on learning experience is invaluable, as it bridges the gap between theoretical knowledge and practical application. Through mentorship, new nurses gain confidence in their clinical competencies, leading to improved client care and safety.[9]

Mentorship also plays a crucial role in professional development. Mentors guide mentees in setting career goals, navigating career paths, and pursuing continuing education opportunities. They offer advice on advancing in the profession, whether through specialization, leadership roles, or academic achievements. This guidance helps nurses achieve their professional aspirations and contribute more effectively to the health care system. Additionally, mentors often serve as role models, demonstrating the qualities and behaviors essential for success in nursing.[10]

8. ANA. (2024). *Mentorship in nursing: Benefits & why it's essential*. https://www.nursingworld.org/content-hub/resources/nursing-resources/benefits-of-mentorship-in-nursing/#:~:text=As%20a%20mentor%2C%20you'll,be%20conducted%20formally%20or%20informally.

9. ANA. (2024). *Mentorship in nursing: Benefits & why it's essential*. https://www.nursingworld.org/content-hub/resources/nursing-resources/benefits-of-mentorship-in-nursing/#:~:text=As%20a%20mentor%2C%20you'll,be%20conducted%20formally%20or%20informally.

10. ANA. (2024). *Mentorship in nursing: Benefits & why it's essential*.

The supportive nature of mentorship fosters emotional and psychological well-being. The transition from nursing school to clinical practice can be challenging and stressful. Having a mentor provides new nurses with a trusted confidant who offers encouragement, listens to concerns, and provides constructive feedback. This support system helps reduce feelings of isolation and burnout, promoting job satisfaction and retention. Mentors can also help new nurses develop coping strategies and resilience, which are critical for long-term success in the demanding field of health care.[11]

Mentorship contributes to the creation of a positive and collaborative workplace culture. By fostering strong relationships between experienced and novice nurses, mentorship programs encourage teamwork, mutual respect, and knowledge sharing. This collaborative environment enhances communication, reduces errors, and improves overall client outcomes. Furthermore, a culture of mentorship promotes lifelong learning and continuous improvement, essential elements for maintaining high standards of care in a rapidly evolving health care landscape. For mentors, the experience is also enriching and rewarding. Mentoring provides opportunities for professional growth, leadership development, and personal satisfaction. It allows experienced nurses to reflect on their own practices, stay current with new trends and technologies, and contribute to the future of the nursing profession. The act of mentoring fosters a sense of purpose and fulfillment,

https://www.nursingworld.org/content-hub/resources/nursing-resources/benefits-of-mentorship-in-nursing/#:~:text=As%20a%20mentor%2C%20you'll,be%20conducted%20formally%20or%20informally.

11. ANA. (2024). *Mentorship in nursing: Benefits & why it's essential*. https://www.nursingworld.org/content-hub/resources/nursing-resources/benefits-of-mentorship-in-nursing/#:~:text=As%20a%20mentor%2C%20you'll,be%20conducted%20formally%20or%20informally.

reinforcing the mentor's commitment to the profession and enhancing their own career satisfaction.[12]

Mentorship is a cornerstone of the nursing profession, offering substantial benefits to individual nurses, health care organizations, and clients. It enhances clinical skills, supports professional development, fosters emotional well-being, and promotes a positive workplace culture. By investing in mentorship programs, health care organizations can ensure the growth and success of their nursing staff, ultimately leading to higher quality care and better client outcomes.

12. ANA. (2024). *Mentorship in nursing: Benefits & why it's essential*. https://www.nursingworld.org/content-hub/resources/nursing-resources/benefits-of-mentorship-in-nursing/#:~:text=As%20a%20mentor%2C%20you'll,be%20conducted%20formally%20or%20informally.

11.6 Lifelong Learner

After graduating, passing the NCLEX-RN, and obtaining your first nursing position, your learning as a nurse has just begun. The first year of your nursing career is a continual process of transitional stages and experiential learning and is the beginning of lifelong learning as a nurse. Lifelong learning can be achieved through a variety of methods, such as obtaining additional nursing degrees, acquiring certifications, joining professional organizations, attending conferences and workshops, and staying up-to-date on current evidence-based practices by reading nursing literature and other research.

Advanced Nursing Degrees

After obtaining an RN license, there are many opportunities to advance your education through accredited schools of nursing. Many health care organizations encourage nurses to obtain higher degrees and provide tuition reimbursement for a BSN and other advanced degrees.

Baccalaureate Degree in Nursing

Many hospitals hire nurses with an Associate's Degree in Nursing (ADN) on a condition they complete their Baccalaureate Degree in Nursing (BSN) within a specific time frame.

Master's Degree in Nursing

A Master's of Science in Nursing Degree (MSN) requires additional credits and years of schooling beyond the BSN. There are a variety of degree options, including, but not limited to, Nurse Educator, Advanced Practice Nurse (APRN), Informatics, Leadership, and Clinical Educators.

Doctoral Degrees in Nursing

Doctoral nursing degrees include the Doctor of Philosophy in Nursing (PhD)

and the Doctor of Nursing Practice (DNP). PhD-prepared nurses complete doctoral work that is focused on research. They often teach in a university setting and/or conduct research. DNP-prepared nurses complete doctoral work that is focused on clinical nursing practice. They typically have work roles in advanced nursing practice, clinical leadership, or academic settings.

Advanced Practice Nurses

Advanced Practice Nurses (APRN) are defined by the NCSBN as an RN who has a graduate degree and advanced knowledge. There are four categories of Advanced Practice Nurses: certified nurse-midwife (CNM), clinical nurse specialist (CNS), certified nurse practitioner (CNP), and certified registered nurse anesthetist (CRNA). APRNs can diagnose illnesses and prescribe treatments and medications. Additional information about advanced nursing degrees and roles is provided in the box below.[1]

Categories of Advanced Practice Nurses

Nurse Practitioners: Nurse practitioners (NPs) work in a variety of settings and complete physical examinations, diagnose and treat common acute illness, manage chronic illnesses, order laboratory and diagnostic tests, prescribe medications and other therapies, provide health teaching and supportive counseling with an emphasis on prevention of illness and health maintenance, and refer clients to other health professionals and specialists as needed. In many states, NPs can function independently and manage their own clinics, whereas in other states physician supervision is required. NP certifications include,

1. Institute of Medicine. (2011). *The future of nursing: Leading change, advancing health.* National Academies Press. https://doi.org/10.17226/12956

but are not limited to, Family Practice, Adult-Gerontology Primary Care, Adult-Gerontology Acute Care, and Psychiatric/ Mental Health.

- To read more about NP certification, visit Nursing World's Our Certifications web page.

Clinical Nurse Specialists: Clinical Nurse Specialists (CNS) practice in a variety of health care environments and participate in mentoring other nurses, case management, research, designing and conducting quality improvement programs, and serving as educators and consultants. Specialty areas include, but are not limited to, Adult/Gerontology, Pediatrics, and Neonatal.

- To read more about CNS certification, visit NACNS's What is a CNS? web page.

Certified Registered Nurse Anesthetists: Certified Registered Nurse Anesthetists (CRNAs) administer anesthesia and related care before, during, and after surgical, therapeutic, diagnostic, and obstetrical procedures, as well as provide airway management during medical emergencies. CRNAs deliver more than 65 percent of all anesthetics to clients in the United States. Practice settings include operating rooms, dental offices, and outpatient surgical centers.

- To read more about CRNA certification, visit NBCRNA's website.

Certified Nurse Midwives: Certified Nurse Midwives (CNM) provide gynecological exams, family planning advice, prenatal care, management of low-risk labor and delivery, and neonatal care. Practice settings include hospitals, birthing centers, community clinics, and client homes.

To read more about CNM certification, visit AMCB Midwife's website.

Specialty Certifications

Acquiring nursing specialty certification is a way to demonstrate expertise. National certifications have various requirements, but most require continuing education credits and successful completion of a national examination. After successfully obtaining a specialty certification, additional credentials are displayed after "RN" in a nurse's signature. See Table 11.6 for a list of common specialty certifications and their associated credentials.

Table 11.6 Nursing Specialty Certification

Certification	Credentials
Critical Care Nursing	CCRN
Certified Nurse Educator	CNE
Oncology Certified Nurse	ONC
Stroke Certified Registered Nurse	SCRN
Trauma Certified Registered Nurse	TCRN
Surgical Nurse	CORN
Nursing Professional Development	NPD-BC

Read more about specialty ANCC nursing certifications.

Professional Organizations

Joining a local, state or national nursing organization is a way to connect with other RNs and promote continued professional growth. The largest national

organization is the American Nurses Association (ANA). The ANA provides RN members with the following benefits:

- Advance your career with free development resources and webinars.
- Stay current with the most up-to-date nursing news.
- Save money with big discounts on continuing education (CE), certification, publications, and more.
- Network and connect with Registered Nurses (RN) for support and advice.
- Make your voice heard with opportunities to tell policymakers what you think.
- Receive state nurse association member benefits.

In addition to the ANA, each state has their own state nursing association.

> Read more about joining the American Nurses Association and your state Nursing Association on the ANA website.

Attending Conferences and Workshops

Regularly attending nursing conferences and workshops is an excellent way to maintain current, evidence-based knowledge and continue to provide safe, quality nursing care. Many opportunities exist for these types of experiences provided by local health care agencies, state nursing associations, or national conferences. Joining local, state, and national nursing organizations is the best way to be aware of upcoming conferences and workshops. See Figure 11.7[2] for an illustration of a lifelong learner and leader.

2. "EFP_2015_speaker_II.jpg" by Adrian Soldati is licensed under CC BY-SA 4.0

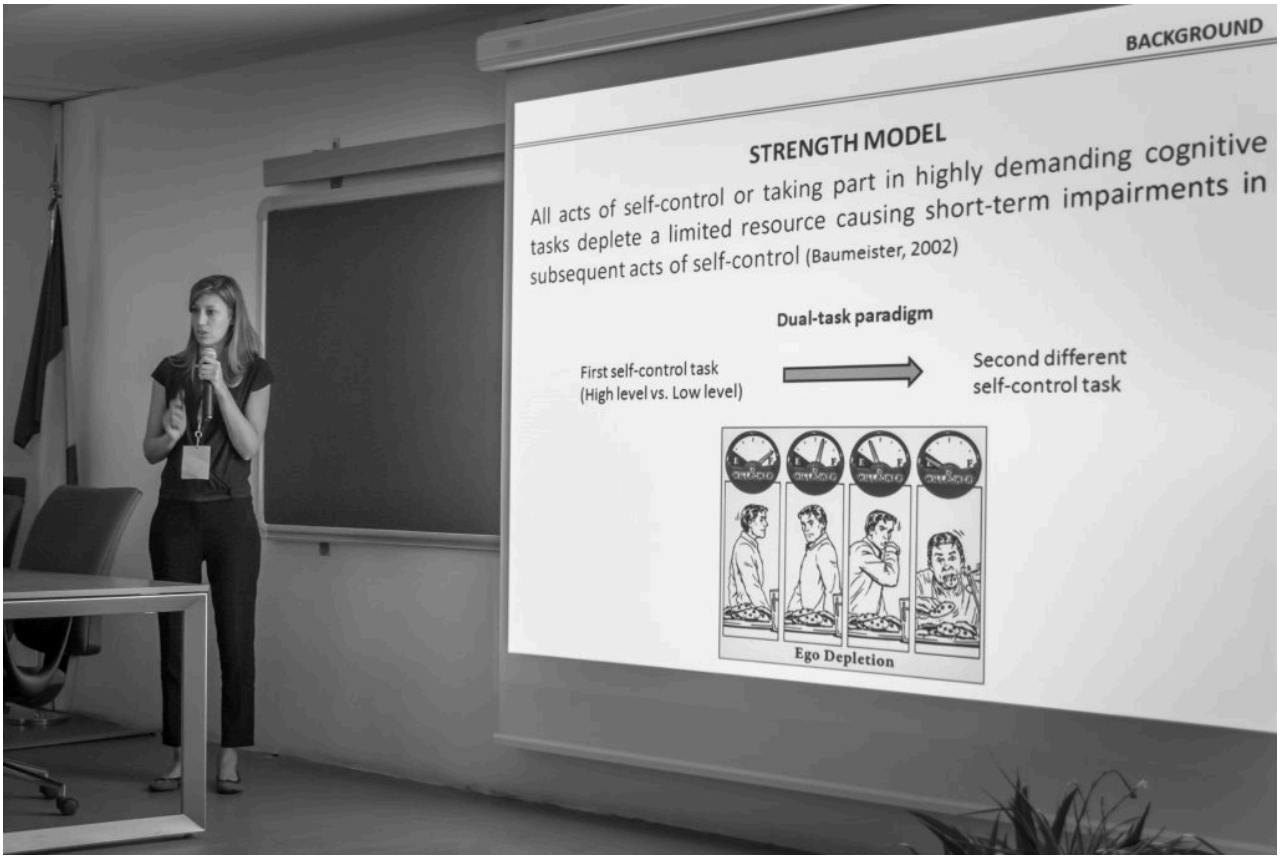


Figure 11.7 Lifelong Learner

Nursing Journals

There are many nursing journals that you can access electronically or have delivered to your home to read regularly. Read more about staying current on evidence-based practices in the "Quality and Evidence-Based Practice" chapter.

11.7 Spotlight Application

James is nearing the end of his associate degree nursing program and is interested in pursuing his first nursing employment opportunity within his community. He has a professional goal of becoming a nurse anesthetist and would like to start as a new graduate in the intensive care unit. He has interviews at three acute care organizations for various ICU positions.

Reflective Questions

1. Prior to the interview process, what employment elements should James consider in relation to each position?
2. What should James research regarding potential employers before his interviews?
3. List important questions for nurses to ask potential employers during the interview process?
4. Considering Benner's Novice to Expert theory, what skills sets might be helpful for James to obtain before starting a position in the ICU and working towards becoming a nurse anesthetist?

As James considers the various positions in each organization, he should take time to learn about the populations served and size of the organizations. Certain client populations may be more beneficial to James's professional development as he progresses in his goal of becoming a nurse anesthetist and, therefore, James should consider what background experience he will gain with each position. Additionally, James should ask potential employers regarding the orientation process within each organization. Intensive care positions can be challenging roles for new graduates, and it is important that James has an understanding of the method of orientation used in the ICU training process. James may also be interested in learning more about tuition reimbursement to facilitate his ongoing education and support from the organization for his continued education.

11.8 Learning Activities

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nursingmpc/?p=499#h5p-17

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nursingmpc/?p=499#h5p-18

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nursingmpc/?p=499#h5p-19

Practice NCLEX Next-Gen Style Questions with the following learning activity:

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nursingmpc/?p=499#h5p-37

- Test your knowledge using this NCLEX Next Generation-style Case Study. You may reset and resubmit your answers to this question an unlimited number of times.[1]



1. "Chapter 11, Assignment 1" by Travis Christman for OpenRN is licensed under CC BY-NC 4.0

XI Glossary

Benner's Novice to Expert Theory: A theory by Dr. Patricia Benner that explains how new hires develop skills and a holistic understanding of client care over time, resulting from a combination of a strong educational foundation and thorough clinical experiences. Benner's theory identifies five levels of nursing experience: novice, advanced beginner, competent, proficient, and expert.

Licensure: The process by which a State Board of Nursing (SBON) grants permission to an individual to engage in nursing practice after verifying the applicant has attained the competency necessary to perform the scope of practice of a registered nurse (RN). The SBON verifies three components:

- Verification of graduation from an approved prelicensure RN nursing education program
- Verification of successful completion of NCLEX-RN examination
- A criminal background check (in some states)[1]

NCLEX-RN: The exam that nursing graduates must pass successfully to obtain their nursing license and become a registered nurse.

NCLEX-RN Test Plan: A concise summary of the content and scope of the NCLEX that serves as an excellent guide for preparing for the exam. These plans are updated every three years based on surveys of newly licensed registered nurses to ensure the NCLEX questions reflect fair, comprehensive, current, and entry-level nursing competency.

Nurse Licensure Compact (NLC): State legislation that allows nurses to practice in other NLC states with their original state's nursing license without having to obtain additional licenses, contingent upon remaining a resident of that state.

1. NCSBN. (2025). *NCLEX*. https://www.ncsbn.org/nclex.htm

Nurse residency programs: A transition process that provides additional professional development for newly licensed nurses. These programs vary from institution to institution, but many start around the time the new graduate ends their orientation with a preceptor and continue to provide routine support throughout the year.

Orientation: A structured transition process when hired into a new position that may last from one to four months but can be longer depending on the specialty (e.g., Intensive Care or Labor and Delivery). Orientation is based on the new nurse's demonstration and completion of competencies. During this time the novice RN will work with a preceptor to experience all the aspects of the role.

Portfolio: A compilation of materials showcasing examples of previous work demonstrating one's skills, qualifications, education, training, and experience.

Preceptors: Experienced and competent RNs who serve as a role model and a resource to a newly hired nurse. These nurses have the knowledge, skills, and the ability to coach the new RN into the nursing role and answer questions while also evaluating a new hire's performance and providing feedback for improvement.

Resume: A document that highlights one's background, education, skills, and accomplishments to potential employers.

Temporary permit: A permit issued by the State Board of Nursing (SBON) that allows the applicant to practice practical nursing under the direct supervision of a registered nurse until their RN license is granted.

PART XII

CHAPTER 12 - BURNOUT AND SELF-CARE

12.1 Burnout & Self-Care Introduction

Learning Objectives

- Identify the impact of situational stressors within the nursing profession
- Develop strategies to mitigate stress and burnout and maintain engagement in the profession

There is a continued demand for nurses due to complex health care issues facing our country and health care institutions across the world. Nursing is a challenging and demanding profession that requires rigorous educational preparation, clinical expertise, compassion, and the physical and mental capacity to meet a variety of health care needs. The complex demands of the profession can lead to professional burnout and workplace attrition as nurses struggle to balance the challenges of their daily work roles, manage personal and organizational stress, and maintain their health and well-being at home. Nurses are often accustomed to putting aside their own needs to provide care, yet a lack of attention to their personal needs can have significant negative professional consequences. In essence, care for others can easily become compromised when care for self is in jeopardy. Additionally, nurses who do not engage in self-care are more at risk for burnout and attrition from the profession, compounding issues associated with staffing shortages and personnel supply to meet health care demands.[1]

To fully consider the implications of stress management within the nursing

1. Waddill-Goad, S. (2016). *Nurse burnout: Combating stress in nursing*. Sigma Theta Tau International.

profession, one must look no further than the challenges that have arisen as a result of the recent COVID-19 pandemic. Each day, news reports highlight the exhaustion being experienced by nurses across the world resulting from health care demands in acute inpatient care, long-term care, school nursing, and public health.[2] With increased job stress, nurses may experience an increased desire to leave the profession and look for other career opportunities.[3] Personal ability to cope with stressors and workplace challenges have been further taxed by ongoing and ever-increasing health care demands. Busy health care systems have struggled to meet care demands as health care personnel have experienced waning professional engagement with decreased time for personal renewal and rejuvenation.

Unfortunately, the COVID-19 pandemic has exacerbated many stressors that previously existed within the nursing profession. This has challenged nurses to find creative methods aimed at increasing self-resilience as a means of meeting the burgeoning health care demands and challenges arising during these uncertain times. Novice nurses who are entering the profession may feel these stressors more acutely than experienced nurses who have already cultivated personal resilience skills. As a result, attention must be given to assisting novice nurses in developing skills to address occupational stress as they navigate their way into the profession.[4] The nursing profession must acknowledge this new challenge for novice nurses and foster strategies and

2. Turale, S., & Nantsupawat, A. (2021). Clinician mental health, nursing shortages and the COVID-19 pandemic: Crises within crises. *International Nursing Review, 68*(1), 12-14. https://doi.org/10.1111/inr.12674

3. Maben, J., & Bridges, J. (2020). Covid-19: Supporting nurses' psychological and mental health. *Journal of Clinical Nursing, 29*(15-16), 2742-2750. https://doi.org/10.1111/jocn.15307

4. Horan, K. M., & Dimino, K. (2020). Supporting novice nurses during the COVID-19 pandemic. *AJN: American Journal of Nursing, 120*(12), 11. https://doi.org/10.1097/01.NAJ.0000724140.27953.d1

resources to provide additional emotional support for the unique needs of this group. Professional mentorship and support are even more important in times when many nurses may question their career choice and personally experience waning engagement with the profession.

Finally, it is important for the nursing profession to acknowledge that even outside of the pandemic environment there are unique challenges for long-term engagement. Nurses entering the profession should acknowledge the inherent nature of the work of nursing that can create measurable highs and lows as individuals provide the care and support needed to facilitate the health and well-being of others. Hours are long and care demands are high. Client care needs revolve around a cycle of illness and do not coincide with holidays, summer vacations, and weekend sports. As a result, many new nurses soon realize that job stress related to the schedule burden can become a challenge. It is one of the inherent job stressors that nurses must seek to resolve and manage. Additionally, nurses must recognize that stress management and personal wellness remain important aspects of professional growth throughout the various phases of their career.

12.2 Stress in the Health Care System

Stress within any health care profession occurs as a result of the challenging and dynamic conditions experienced in day-to-day work. See Figure 12.1[1] for an illustration of stress in a health care environment. Nurses and health care professionals are taxed with supporting clients and families in times of extensive life stress and change. Individuals who seek out care often experience rapid life changes as the result of a new diagnosis, altered body function, death of a family member, or significant mental distress. Nurses are frontline staff members who help clients and their families navigate these health stressors. It can be difficult to provide frontline support without taking on some of the stress encountered. As clients and families navigate their feelings of fear, frustration, anxiety, and anger, nurses are often the support members who first hear and react to these feelings. It is important to recognize the constant barrage of these emotions can take a toll, and it is challenging to not assume this emotional burden.

1. "Emergency_medicine_simulation_training_exercise_in_Balad%2C_Iraq.jpg" by Robert Couse-Baker is licensed under CC BY 2.0



Figure 12.1 Stress in the Health Care Environment

In addition to the emotional burden of providing support for multiple clients and their family members, nurses experience a variety of other stressors inherent to the health care environment itself. These stressors include issues such as environmental stress, increased workload, changing practice conditions, lack of resources, communication barriers, unfavorable working conditions, frequency of engagement with a variety of personnel, challenges in care coordination, workplace violence, alarm fatigue, and staff turnover. Research has identified that the variety of stressors experienced by nursing staff result in inherently greater levels of stress than that experienced in the wider working population.[2] Therefore, nurses must acknowledge the variety of stressors they encounter within the profession and identify strategies to mitigate these forces.

2. Waddill-Goad, S. (2016). *Nurse burnout: Combating stress in nursing*. Sigma Theta Tau International.

Nursing is charged with emotional situations and topics even on days when no other situational stressors have significant impact. One cannot participate in the significant conversations that accompany health care decision-making, provide client education, and promote individual coping without acknowledging these conversations are more impactful than deciding, "What should we make for dinner?" By acknowledging this inherent job stress, nurses recognize that eliminating stress within the profession is not possible. There will always be a level of stress that accompanies the health care environment, and this underscores the importance of stress identification, mitigation, and incorporation of stress-reduction strategies.[3]

3. Waddill-Goad, S. (2016). *Nurse burnout: Combating stress in nursing*. Sigma Theta Tau International.

12.3 Identifying Stress in Self

Health care professionals must recognize emerging signs of stress that may result from job demands and the nature of health care work. There are a variety of ways that stress can manifest itself. Taking action early can help to prevent workplace burnout. **Burnout** can be manifested physically and psychologically with a loss of motivation for one's work. Nurses and other health care professionals must mitigate stress and burnout to sustain engagement with their profession. Failure to acknowledge the implications of professional burnout only exacerbates the cycle as stressors are transferred to remaining team members and colleagues, resulting in the potential for attrition and turnover.

Although the term "stress" often has negative connotations, it is important to remember that not all stress is considered harmful. **Normal stress,** also referred to as "eustress," does not have lasting consequences and is successfully managed by the individual who is experiencing it.[1] Normal stress, when successfully managed, can increase awareness and focus, resulting in feelings of motivation and competence in the individual who is experiencing it. For example, normal stress may be experienced by a nursing student as they organize their weekly planner specifying time for class, study time, work shifts, or meeting with friends. Although the calendar looks busy, the student can use the stress resulting from a "time-constrained schedule" to motivate oneself to be efficient in completing tasks. This student may feel great satisfaction as they cross off tasks on the "to-do" list. Hopefully, as task achievement occurs, the student transitions from feelings of stress to feelings of empowerment.

Conversely, harmful stress, also referred to as "distress," occurs when stress is not adequately self-managed. **Harmful stress** is reflected by physical, mental,

1. Bamber, M. R. (2011). *Overcoming your workplace stress: A CBT-based self-help guide*. Routledge.

and behavioral manifestations.[2] See Figure 12.2[3] for an illustration of an individual experiencing harmful stress. Harmful stress can lead to burnout and exhaustion, and if left unaddressed, it can have significant health implications for the individual experiencing it. Let's return to the example of the nursing student reviewing their busy schedule. Harmful stress can be experienced by a student looking at their busy weekly schedule and feeling overwhelmed and exhausted. Rather than focusing on manageable tasks and crossing items off the list, this student is reluctant to take action and feels distress regarding where to begin. The student demonstrating harmful stress may struggle with overwhelming fatigue, irritability, and may feel overwhelmed with feelings of inadequacy at one's ability to meet the task requirements.



Figure 12.2 Harmful Stress

Harmful stress can impact the employment setting as well. It can damage

2. Bamber, M. R. (2011). *Overcoming your workplace stress: A CBT-based self-help guide*. Routledge.
3. "4347213145_bec129a6ae.jpg" by Michael Clesle is licensed under CC BY-NC 2.0

staff engagement, cause significant physical manifestations, and impede the ability of the employee to safely perform work. Harmful stress can quickly result in the breakdown of collegial relationships and also influence the overall practice environment. Potential signs of harmful stress are described in Table 12.3.

Table 12.3. Harmful Stress: Physical, Mental, & Behavioral Manifestations[4]

4. Bamber, M. R. (2011). *Overcoming your workplace stress: A CBT-based self-help guide*. Routledge.

Physical	Headache Joint discomfort Sleep disturbance Cardiac abnormality (e.g., heart rate, rhythm changes) Increased blood pressure Dry mouth Indigestion Constipation or diarrhea Excessive sweating Dizziness Tremors
Mental	Anger Irritability Mood changes Depression Conflict with friends, family members, coworkers Isolation of self from others Reduced self-confidence
Behavioral	Increased alcohol consumption Smoking or drug use Overeating or loss of appetite Increased arguments with coworkers Increased errors in the workplace

Nurses and health care professionals should be mindful of the physical, mental, and behavioral manifestations of harmful stress so prompt action can

be taken when signs begin to occur. Harmful stress must be addressed early so it does not continue to evolve and lead to career burnout. Additionally, stress can have significant implications beyond one's career. An individual's physical and emotional health and well-being are strongly aligned with positive stress management. Harmful stress that goes unaddressed can lead to unresolved physical ailments, deterioration in mental and physical well-being, and the breakdown of familial relationships. The negative impact of harmful stress can be difficult to overcome after it has taken hold of an individual.

It can be helpful to mindfully gauge how one is handling stress on a routine basis. See the link to the Perceived Stress Scale in the following box.

- Gauge your current level of stress using the State of New Hampshire's Perceived Stress Scale.

Stressors Resulting From the COVID-19 Pandemic

In addition to the inherent stressors that can occur in health care settings as a result of normal job-related tasks and demands, unique challenges and stressors have occurred for nurses as a result of the COVID-19 pandemic. See Figure 12.3[5] for an image of a COVID care provider. *The Future of Nursing 2020-2030* highlights the impact of the COVID-19 pandemic on the profession. The COVID pandemic has placed extraordinary demands on nurses as they try to meet ever-expanding health care challenges placed on them. Hospitals are continuously overcrowded and needed medical equipment can be sparse.[6] Nurses are asked to provide frontline care to

5. "49855067292_d521d20931_o-e1626806176568.jpg" by Ted Eytan is licensed under CC BY-SA 4.0

6. National Academies of Sciences, Engineering, and Medicine. (2021). *The future*

infectious clients with transmission-based precautions in isolation rooms.[7] These nurses then return to their home environments, hoping that they do not spread infection to their families while supporting the needs of the family unit. These continuous job and life stressors compound the physical and psychological demands on nurses. With little respite care for themselves, nurses are at risk for the impact of compounding stressors on their own health.

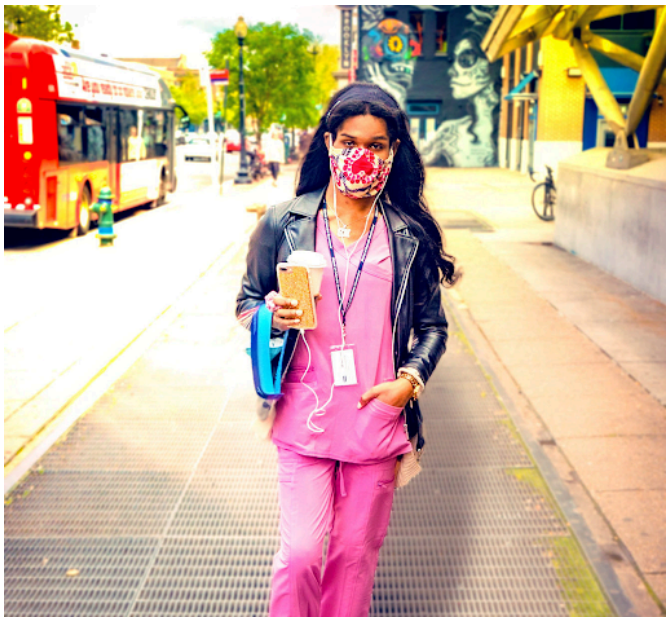


Figure 12.3 COVID Care Provider

> Read a meta-analysis about interventions to support the resilience and mental health of frontline professionals during a pandemic.

of nursing 2020-2030: Charting a path to achieve health equity. The National Academies Press. https://doi.org/10.17226/25982

7. National Academies of Sciences, Engineering, and Medicine. (2021). *The future of nursing 2020-2030: Charting a path to achieve health equity.* The National Academies Press. https://doi.org/10.17226/25982

12.4 Acknowledging Stress in Others

In addition to recognizing stress manifestations in oneself, health care professionals must identify signs of stress in others. All members of the health care team experience stress, and effective coping can quickly turn into ineffective coping when manageable, normal stress shifts to harmful stress. Nurses should understand how stress may manifest in a colleague and how one can help and intervene if signs of harmful stress occur.

The signs of harmful stress in a colleague often manifest in a similar manner to what is seen in oneself, but certain signs may be more readily identified by an external source. It is not unusual to identify the mental or behavioral signs of harmful stress in a colleague more rapidly than the physical manifestations. Individuals should be mindful of signs of harmful stress in others, such as changes in mood, irritability, signs of fatigue, increased errors, and absenteeism.[1] Individuals exhibiting these signs may be signaling they are struggling to manage harmful stress. It is important to promptly address these signs with the individual. The tendency to assume one can self-manage or will "get over it" can lead to feelings of isolation that will only perpetuate the stress.

When observing potential signs of harmful stress in a colleague, providing an opportunity to discuss the stressors can be a valuable avenue for promoting effective coping. It is important to remember that the individual exhibiting signs of harmful stress may not recognize they are impacted by stress, but having a colleague acknowledge one's change in mood or attitude can open the opportunity for self-reflection. Although acknowledging signs of harmful stress in a colleague may feel awkward, asking if someone is okay and addressing signs of potential harmful stress can be a significant step in

1. Burton, A., Burgess, C., Dean, S., Koutsopoulou, G. Z., & Hugh-Jones, S. (2017). How effective are mindfulness-based interventions for reducing stress among healthcare professionals? A systematic review and meta-analysis. *Stress and Health, 33*(1), 3-13. https://doi.org/10.1002/smi.2673

helping them cope. Acknowledgement can occur with statements such as, "I noticed that you seem more frustrated at work lately. Is everything okay?" or "You seem to be more quiet in the breakroom after our shifts. How are you feeling? I know the busy days can really add up." Simple statements and questions open opportunities to share feelings and frustrations and also demonstrate caring for team members.[2] This approach creates dialogue about stressful experiences and provides support needed to positively address harmful stress.

In addition to demonstrating care for one's colleague by inviting conversation about harmful stress, sharing resources is also helpful. It is important for nurses to know they are not alone in experiencing feelings of stress, and attention to these feelings can help one develop strategies to positively address them. Planning discussions with a trusted mentor or friend can be very helpful when exploring feelings related to stress. These discussions also provide an opportunity to share information regarding coping strategies such as mindfulness interventions, resiliency programs, or other formalized resources like employee assistance programs.[3] There are also routine workplace measures that significantly impact stress reduction. For example, many nurses do not take the time to ensure they are taking breaks, eating healthy meals, or simply removing themselves from the care environment for brief periods of time. Simple strategies that can dramatically reduce workplace stress include taking a brief walk outside during one's lunch break

2. Babore, A., Lombardi, L., Viceconti, M. L., Pignataro, S., Marino, V., Crudele, M., Candelori, C., Bramanti, S. M., & Trumello, C. (2020). Psychological effects of the COVID-2019 pandemic: Perceived stress and coping strategies among healthcare professionals. *Psychiatry Research, 293*, 113366. https://doi.org/10.1016/j.psychres.2020.113366

3. Dossett, M. L., Needles, E. W., Nittoli, C. E., & Mehta, D. H. (2021). Stress management and resiliency training for healthcare professionals. *Journal of Occupational and Environmental Medicine, 63*(1), 64-68. https://doi.org/10.1097/jom.0000000000002071

or taking a few deep breaths prior to the beginning of a work shift. Other simple measures such as daily exercise and meditation can reduce stress and increase confidence to address the tasks at hand.[4] Although experienced nurses may already be incorporating these strategies, it is important for novice nurses to understand the value of these strategies.

4. Perciavalle, V., Blandini, M., Fecarotta, P., Buscemi, A., Di Corrado, D., Bertolo, L., Fichera, F., & Coco, M. (2017). The role of deep breathing on stress. *Neurological Sciences, 38*, 451–458. https://doi.org/10.1007/s10072-016-2790-8

12.5 Organizational Stress & Retention Cycle

The impact of inadequate stress management for health care personnel can greatly impact health care organizations. When harmful stress is not adequately addressed, burnout can rapidly become a burgeoning problem resulting in absenteeism, decreased productivity, decline in care quality, staff dissatisfaction, and employee turnover. Work environment and lack of workplace support often contribute to feelings of burnout and job attrition.[1] Organizations must recognize the significance of stress in regard to the cyclical nature it plays in the retention of employees. For example, if one employee experiences harmful stress resulting in depression and anxiety, this may influence their timeliness and attendance at work. If the employee begins to struggle, they may be more inclined to phone in as "sick time" for shifts or even be a "no show" for a scheduled shift. When this occurs, the burden of their absence is passed on to other employees on the unit. Calls for overtime, mandated stay, or increased client care assignments quickly increase the burden on the other members of the health care team. As a result, the team members experiencing increased workload feel an impact on their own job-related stress. The compounded stress can quickly overtax an individual who has been managing normal work-related stress. Many individuals who were previously self-managing stress may struggle under these increased role demands. When there is a decrease in an individual's "downtime," there is even less reprieve from the stressful work environment. As a result, the organization and health care system become even more overtaxed, and the cycle perpetuates itself among other staff.[2] Managers and

1. Mercado, M., Wachter, K., Schuster, R. C., Mathis, C. M., Johnson, E., & Davis, O. I. (2022). A cross-sectional analysis of factors associated with stress, burnout and turnover intention among healthcare workers during the COVID-19 pandemic in the United States. *Health & Social Care in the Community*. https://doi.org/10.1111/hsc.13712

2. Chegini, Z., Asghari Jafarabadi, M., & Kakemam, E. (2019). Occupational stress,

directors often struggle with rehiring and orienting staff at a rate that is suitable to offset the stress cycle and decreased retention within the organization.

Promoting Nurse Retention

Nurse leaders must be proactive in finding solutions to address clinical nurse and nursing faculty shortages and high nurse turnover rates. The *2018 National Healthcare Retention and RN Staffing Report* states the following data[3]:

- The U.S. Bureau of Labor Statistics reports that 233,000 new RN jobs will be created annually.
- Forty-five percent of hospitals anticipate increasing their RN staff.
- Hospital turnover is at 18.2%, an increase from previous years.
- RNs working in emergency care, step-down, and medical-surgical units experience high turnover rates, with the highest rate of turnover for certified nursing assistants.
- The average cost of each RN turnover is $49,500, resulting in an average hospital losing an estimated $4.4 to $7 million due to turnover.
- Each percent change in RN turnover will cost or save the average hospital $337,500.
- It takes approximately 2.5 months to recruit an experienced RN.
- More than half of hospitals would like to decrease reliance on supplemental staffing.
- For every 20 travel RNs eliminated, a hospital can save an average of $1,435,000.

quality of working life and turnover intention amongst nurses. *Nursing Critical Care, 24,* 283-289. https://doi-org.ezproxy.liberty.edu/10.1111/nicc.12419

3. Kroning, M., & Hopkins, K. (2019). Healthcare organizations thrive with shared governance. *Nursing Management, 50*(5), 13-15. https://doi.org/10.1097/01.numa.0000557781.40049.2d

Unfortunately, many nurse leaders struggle to receive organizational support for recruitment and hiring in a timely fashion. Demonstrating the need for staff replacement often cannot be established until a staff vacancy exists. As a result, the retention cycle is further compromised when workload is impacted due to staff vacancies during the recruitment and orientation process. Many frontline nursing staff may not be aware of the rigorous challenges that nurse leaders face when requesting administrative support for additional staff positions. Most organizations require executive-level approval for hiring, and unit productivity is examined for rationale that additional staff are needed. The time required for this investigation and executive-level approval can be very challenging for staff nurses who experience the workload burden during the vacancies. During this time frame, nurse leaders may struggle to maintain team morale while also acknowledging the organization's need to be financially responsible in staff hiring.

It is important for all parties to remain engaged in their current work roles during the recruitment, hiring, and orientation periods of new nurses. Trust in one another during this time is critical, and all parties must remember the needs of clients receive top priority. Providing optimal care to the best of one's ability is of the utmost importance even when experiencing staffing challenges. Additionally, staff, nursing leaders, and administrators within the organization must unite to find actionable solutions that acknowledge the impact of stress and reduce the impact of harmful stress contributing to the burnout of colleagues. There is no simple solution. All individuals must be united in exploring strategies to reduce the occurrence of burnout and seek to make change to enhance the health and well-being of all involved.

12.6 Mitigating Stress With Self-Care

As previously discussed, the action of providing nursing care can result in significant stress. The stress response is exacerbated when experiencing extreme or repeated stressors, such as client deaths. In some health care settings, nurses do not have time to resolve grief from one loss before another death occurs.

Compassion fatigue and burnout occur frequently with nurses and other health care professionals who experience cumulative deaths that are not addressed therapeutically. Compassion fatigue is a state of chronic and continuous self-sacrifice and/or prolonged exposure to difficult situations that affect a health care professional's physical, emotional, and spiritual well-being. This can lead to a person being unable to care for or empathize with someone's suffering. Additionally, many individuals who experience compassion fatigue may become detached from the emotions associated with the care experience or client needs. These individuals can often appear numb to the severity of the circumstance of the events that are occurring. **Burnout** can be manifested physically and psychologically with a loss of motivation. It can be triggered by workplace demands, lack of resources to perform work professionally and safely, interpersonal relationship stressors, or work policies that can lead to diminished caring and cynicism.[1] See Figure 12.4[2] for an image depicting a nurse at home experiencing burnout due to exposure to multiple competing demands of work, school, and family responsibilities.

1. Lowey, S. E. (2015). Nursing care at the end of life. Open Library. https://ecampusontario.pressbooks.pub/nursingcare/

2. "Burnout_At_Work_-_Occupational_Burnout.jpg" by Microbiz Mag is licensed under CC BY 2.0



12.4 Burnout

With the significant dangers of burnout and compassion fatigue within the nursing profession, it is important to acknowledge actions and strategies to facilitate self-care. Self-care can occur in many actions that individuals take to maintain self-health and is critically important for preventing compassion fatigue and burnout.

To facilitate self-care, nurses must recognize the need to take time off, seek out individual healthy coping mechanisms, and voice concerns within their workplace. Prayer, meditation, exercise, art, and music are examples of healthy coping mechanisms that nurses can use for self-care. Nurses should reflect on what actions bring them personal satisfaction and rejuvenation. These strategies should then be purposefully included to help reduce the influence of work-related stressors. For example, perhaps you are a nurse working in a busy Level 1 trauma center and emergency department. You are nearing the end of your third 12-hour shift and have the following day off. The unit manager approaches you and states that there has been an ill call for tomorrow's evening shift. You are offered premium pay to come in and work. Although there is a part of you that is interested in receiving the premium pay, you also take a moment to think about your current situation. You are tired from working three 12-hour shifts the last three days and had plans to go

to your child's baseball game tomorrow evening. Taking stock of these reflective thoughts, you politely decline the additional shift. Acknowledging your fatigue and the satisfaction that you will feel in attending your child's game are important parts of facilitating self-care. Although you could have chosen to work the shift, taking time to look inwardly on what will bring about the greatest rejuvenation and avoid burnout will help cultivate professional engagement.

Additionally, nurses must recognize when outside resources are needed to mitigate stress and facilitate self-care. Many organizations sponsor employee assistance programs that provide counseling services. These programs can be of great value and benefit in allowing individuals to share both individual and employment stressors. For example, employee assistance programs can address employment-related stressors, such as cumulative client deaths, as well as personal challenges impacting one's work role, such as a family illness. The support of an impartial, trained professional can be very helpful as individuals navigate through stressful stimuli.

There are specific stress stimuli that may require specialized intervention. For example, after a client death resulting from trauma, many organizations hold debriefing sessions to allow individuals who participated in care to come together to verbalize their feelings. These sessions are often held with the support of chaplains to facilitate individual coping and verbalization of feelings. Debriefing sessions can be very helpful as individuals experience collegial support in working through traumatic stress stimuli.

> Read more about the role of chaplains in facilitating coping in the "Spirituality" chapter in Open RN *Nursing Fundamentals, 2e*.

Reflective Questions

Throughout your nursing career, there will be times to stop and pay attention to warning signs of compassion fatigue and burnout. Here are some questions to consider:

- Has my behavior changed?
- Do I communicate differently with others?
- What destructive habits tempt me?
- Do I project my inner pain onto others?[3]

Strategies for Self-Care

By becoming self-aware regarding signs of stress, you can implement self-care strategies to prevent compassion fatigue and burnout. Use the following "A's" to assist in building resilience, connection, and compassion:

- **Attention:** Become aware of your physical, psychological, social, and spiritual health. For what are you grateful? What are your areas of improvement? This protects you from drifting through life on autopilot.
- **Acknowledgement:** Honestly look at all you have witnessed as a health care professional. What insight have you experienced? Acknowledging the pain of loss you have witnessed protects you from invalidating the experiences.
- **Affection:** Choose to look at yourself with kindness and warmth. Affection prevents you from becoming bitter and "being too hard" on yourself.
- **Acceptance:** Choose to be at peace and welcome all aspects of yourself. By accepting both your talents and imperfections, you can protect

3. Lowey, S. E. (2015). Nursing care at the end of life. Open Library. https://ecampusontario.pressbooks.pub/nursingcare/

yourself from impatience, victim mentality, and blame.[4]

Cultivating Care of Self

Taking care of oneself can feel as if it goes against the nature of the nursing role, but it is a vital component for professional success. Provision 5 of the American Nurses Association Code of Ethics states, "The nurse owes the same duties to self as to others, including the responsibility to promote health and safety, preserve wholeness of character and integrity, maintain competence, and continue personal and professional growth."[5] In a profession where one spends most of their time thinking about the needs of others, it can be difficult to recognize when special care and attention is needed for one's own health. However, there are many strategies that nurses can use to help them navigate stress and prioritize their own health and wellness. Although not every strategy may be "right" for every nurse, it is critical for nurses to find actionable interventions to help them address their own stress.

Here are some examples of stress management strategies:

- **Meditation.** Meditation can induce feelings of calm and clear-headedness, improving concentration and attention. Research has shown that meditation increases the brain's gray matter density, which can reduce sensitivity to pain, enhance the immune system, help regulate difficult emotions, and relieve stress. Mindfulness meditation in particular has been proven helpful for people with depression and anxiety, cancer, fibromyalgia, chronic pain, rheumatoid arthritis, type 2 diabetes, chronic

4. Lowey, S. E. (2015). Nursing care at the end of life. Open Library. https://ecampusontario.pressbooks.pub/nursingcare/

5. American Nurses Association. (2015). *Code of ethics for nurses with interpretive statements*. American Nurses Association. https://www.nursingworld.org/practice-policy/nursing-excellence/ethics/code-of-ethics-for-nurses/coe-view-only/

fatigue syndrome, and cardiovascular disease.[6] See Figure 12.5[7] for an image of an individual participating in meditation.



Figure 12.5 Meditation

- **Yoga.** Yoga is a centuries-old spiritual practice that creates a sense of union within the practitioner through physical postures, ethical behaviors, and breath expansion. The systematic practice of yoga has been found to reduce inflammation and stress, decrease depression and anxiety, lower blood pressure, and increase feelings of well-being.[8] See Figure 12.6[9] for an image of an individual participating in yoga.

6. Delagran, L. (n.d.). *What is spirituality?* University of Minnesota. https://www.takingcharge.csh.umn.edu/what-spirituality

7. "yoga-class-a-cross-legged-palms-up-meditation-position-850×831.jpg" by Amanda Mills, USCDCP on Pixnio is licensed under CC0

8. Delagran, L. (n.d.). *What is spirituality?* University of Minnesota. https://www.takingcharge.csh.umn.edu/what-spirituality



Figure 12.6 Yoga

- **Journaling.** Journaling can help a person become more aware of their inner life and feel more connected to experiences. Studies show that writing during difficult times may help a person find meaning in life's challenges and become more resilient in the face of obstacles. When journaling, it can be helpful to focus on three basic questions: What experiences give me energy? What experiences drain my energy? Were there any experiences today where I felt alive and experienced "flow"? Allow yourself to write freely, without stopping to edit or worry about spelling and grammar.[10]
- **Prayer.** Prayer can elicit the relaxation response, along with feelings of hope, gratitude, and compassion, all of which have a positive effect on overall well-being. There are several types of prayer rooted in the belief that there is a higher power that has some level of influence over one's

9. "9707554768.jpg" by Dave Rosenblum is licensed under CC BY 2.0

10. Delagran, L. (n.d.). *What is spirituality?* University of Minnesota. https://www.takingcharge.csh.umn.edu/what-spirituality

life. This belief can provide a sense of comfort and support in difficult times. A recent study found that clinically depressed adults who believed their prayers were heard by a concerned presence responded much better to treatment than those who did not believe.[11]

- **Spiritual community.** Join a spiritual group, such as a church, synagogue, temple, mosque, meditation center, yoga class, or other local group that meets to discuss spiritual issues. The benefits of social support are well-documented, and having a spiritual community to turn to for fellowship can provide a sense of belonging and support.[12]
- **Nurturing relationships.** Relationships with family, significant others, and friends aren't static – they are living, dynamic aspects of our lives that require attention and care. To benefit from strong connections with others, you should take charge of your relationships and put in the time and energy you would any other aspect of your well-being. It can be helpful to create rituals together. With busy schedules and the presence of online social media that offer the façade of real contact, it's very easy to drift from friends. Research has found that people who deliberately make time for gatherings or trips enjoy stronger relationships and more positive energy. An easy way to do this is to create a standing ritual that you can share and that doesn't create more stress, such as talking on the telephone on Fridays or sharing a walk during lunch breaks.[13]
- **Mindfulness. Mindfulness** has been defined as, "Awareness that arises through paying attention, on purpose, in the present moment, and nonjudgmentally." Mindfulness has also been described as, "Non-elaborative, nonjudgmental, present-centered awareness in which each

11. Delagran, L. (n.d.). *What is spirituality?* University of Minnesota. https://www.takingcharge.csh.umn.edu/what-spirituality

12. Delagran, L. (n.d.). *What is spirituality?* University of Minnesota. https://www.takingcharge.csh.umn.edu/what-spirituality

13. Delagran, L. (n.d.). *What is spirituality?* University of Minnesota. https://www.takingcharge.csh.umn.edu/what-spirituality

thought, feeling, and sensation that arises is acknowledged and accepted as it is." Mindfulness helps us be present in our lives and gives us some control over our reactions and repetitive thought patterns. It helps us pause, get a clearer picture of a situation, and respond more skillfully. Compare your default state to mindfulness when studying for an exam in a difficult course or preparing for a clinical experience. What do you do? Do you tell yourself, "I am not good at this" or "I am going to look stupid"? Does this distract you from paying attention to studying or preparing? How might it be different if you had an open attitude with no concern or judgment about your performance? What if you directly experienced the process as it unfolded, including the challenges, anxieties, insights, and accomplishments, while acknowledging each thought or feeling and accepting it without needing to figure it out or explore it further? If practiced regularly, mindfulness helps a person start to see the habitual patterns that lead to automatic negative reactions that create stress. By observing these thoughts and emotions instead of reacting to them, a person can develop a broader perspective and can choose a more effective response.[14]

- **Nature.** Spending time in nature is cited by many individuals as a spiritual practice that contributes to their mental health.[15]
- **Physical activity.** Regular physical activity, such as brisk walking, can relieve stress and tension.[16]

14. Delagran, L. (n.d.). *What is spirituality?* University of Minnesota. https://www.takingcharge.csh.umn.edu/what-spirituality

15. Yamada, A., Lukoff, D., Lim, C., & Mancuso, L. (2020). Integrating spirituality and mental health: Perspectives of adults receiving public mental health services in California. *Psychology of Religion and Spirituality, 12*(3), 276–287. https://doi.org/10.1037/rel0000260

16. American Heart Association. (2024). *Working out to relieve stress*. https://www.heart.org/en/healthy-living/healthy-lifestyle/stress-management/working-out-to-relieve-stress

Explore additional free resources regarding well-being and resilience:

- American Nurses Association Healthy Nurse Healthy Nation

12.7 Emerging Models

With the increased emphasis on the impact of stress for health care professionals, many organizations and nursing programs have identified resources for formal stress reduction and mitigation. See Figure 12.7[1] for an illustration of stress management. Many of these models and resources have emerged as a professional necessity to help facilitate coping for individuals encountering innumerable job-related stressors. The U.S. Department of Veterans Affairs developed a Stress First Aid (SFA) framework to improve stress management in oneself and in others.[2] Many organizations are moving to frameworks such as the Stress First Aid framework and other stress management programs to help provide health care professionals with the knowledge, skills, and resources to aid in stress management reduction.

The Stress First Aid (SFA) framework offers the health care professional an opportunity to examine stress along a continuum, from normal stress that allows for adaptive functioning to signs of harmful stress requiring intensive intervention. It provides health care professionals with core functions for progressing through stress identification and resolution. The seven core functions are: Check, Coordinate, Cover, Calm, Connect, Competence, and Confidence.[3] The SFA model encourages health care professionals to self-reflect on a stress experience and take action to facilitate self-resolution and resource identification.

1. "stress-management.html" by Nick Youngson is licensed under CC BY-SA 3.0
2. Watson, P., & Westphal, R.J. (2020). *Stress First Aid for Health Care Workers*. National Center for PTSD. https://www.ptsd.va.gov/disaster_events/for_providers/stress_first_aid.asp.
3. Watson, P., & Westphal, R.J. (2020). *Stress First Aid for Health Care Workers*. National Center for PTSD. https://www.ptsd.va.gov/disaster_events/for_providers/stress_first_aid.asp.



Figure 12.7 Stress Management

Many health care organizations embrace wellness as a foundational tenet of workplace culture. They have dedicated wellness committees or wellness champions who promote initiatives aimed at improving stress management among staff.[4] These formalized committees or positions reflect organizational commitment to the importance of self-care and personal wellness. When nursing graduates are interviewing for their first nursing positions, wellness initiatives may be a consideration when exploring professional employment benefits and organizational support structures.

The impact of wellness and stress-reduction strategies is often included in new hire orientation and nurse residency programs. Many nurse residency programs formally acknowledge in their curriculum that novice nurses must

4. Mayzell, G. (2020). *The resilient healthcare organization: How to reduce physician and healthcare worker burnout* (1st ed.). Productivity Press. https://doi.org/10.4324/9780429286025

be educated about the signs of stress.[5] Novice nurses are particularly vulnerable to harmful stressors during their role transition. Many organizations provide training about strategies and resources to assist with coping and stress reduction, which is referred to as resiliency training programs.[6] **Resiliency training** fosters feelings of mindfulness, sensitivity to self, and professional development techniques that contribute to long-term engagement in the profession.

> Read about ways to manage stress from the U.S. Department of Health and Human Services Office on Women's Health.

5. Chesak, S. S., Morin, K. H., Cutshall, S., Carlson, M., Joswiak, M. E., Ridgeway, J. L., Vickers, K. S., & Sood, A. (2019). Stress management and resiliency training in a nurse residency program: Findings from participant focus groups. *Journal for Nurses in Professional Development, 35*(6), 337-343. https://doi.org/10.1097/NND.0000000000000589

6. Chesak, S. S., Morin, K. H., Cutshall, S., Carlson, M., Joswiak, M. E., Ridgeway, J. L., Vickers, K. S., & Sood, A. (2019). Stress management and resiliency training in a nurse residency program: Findings from participant focus groups. *Journal for Nurses in Professional Development, 35*(6), 337-343. https://doi.org/10.1097/NND.0000000000000589

12.8 Spotlight Application

You have been working for six months on a medical telemetry floor and notice a change in your colleague Allie. Allie has been showing up to work late for her shifts and recently made a medication error when drawing up insulin. She mentions to you in the break room that she is having trouble sleeping and has been struggling with migraine headaches. Her husband was recently laid off from his position with a local manufacturing company, so Allie has been volunteering for extra shifts and overtime. Allie is typically good-natured and has a great sense of humor, but lately she has been short-tempered and irritable. As her friend and colleague, you want to see if there is anything that you can do to help

Reflective Questions

1. Using your own words, how would you address your concerns with Allie?
2. What strategies and assistance could you offer her?

As Allie's colleague, you note many signs of harmful stress beginning to manifest in Allie's physical, mental, and behavioral health. One of the first actions that you could take would be to invite Allie to discuss what you have noticed lately. Allie may not even realize that she has been exhibiting signs of ineffective coping and harmful stress. Opening the opportunity to discuss what you have seen and demonstrating that you acknowledge that she is in distress are important steps. Additionally, it is important to discuss with Allie what other resources are available to her. She may wish to reach out to the organization's employee assistance program for assistance, or there may be other organizational resources available to her. Allie should also be encouraged to reach out to her manager to discuss the challenges that she is currently experiencing. This is an important part of mobilizing the resources around her so that she can continue as a successful employee within the organization.

12.9 Learning Activities

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https://wtcs.pressbooks.pub/nursingmpc/?p=1095#h5p-31

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nursingmpc/?p=1095#h5p-32

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nursingmpc/?p=1095#h5p-33

Test your knowledge using this NCLEX Next Generation-style Case Study. You may reset

- and resubmit your answers to this question an unlimited number of times.[1]

1. “Chapter 12, Assignment 1” by Travis Christman for OpenRN is licensed under CC BY-NC 4.0

XII Glossary

Burnout: A condition manifested physically and psychologically with a loss of motivation.

Compassion fatigue: A state of chronic and continuous self-sacrifice and/or prolonged exposure to difficult situations that affect a health care professional's physical, emotional, and spiritual well-being.

Harmful stress: Stress (also referred to as "distress") not adequately self-managed resulting in physical, mental, and behavioral consequences.[1]

Mindfulness: Awareness that arises through paying attention, being on purpose and in the present moment, and being nonjudgmental.

Normal stress: Stress (also referred to as "eustress") that does not have lasting consequences and is successfully managed by the individual who is experiencing it.[2]

Resiliency training: Educational sessions that foster feelings of mindfulness and sensitivity to self and cultivate professional development techniques that contribute to long-term engagement in the profession.

Self-care: Actions that individuals take to maintain health of oneself.

1. Bamber, M. R. (2011). *Overcoming your workplace stress: A CBT-based self-help guide*. Routledge.
2. Bamber, M. R. (2011). *Overcoming your workplace stress: A CBT-based self-help guide*. Routledge.

PART XIII

ANSWER KEYS

Chapter 1

This chapter is an overview and does not include accompanying learning activities.

Answer Key to Chapter 2 Learning Activities

1. Select the assessment findings requiring immediate follow-up by the nurse.

Vital Signs	
Temperature	98.9 °F (37.2°C)
Heart Rate	***182 beats/min***
Respirations	***36 breaths/min***
Blood Pressure	152/90 mm Hg
Oxygen Saturation	***88% on room air***
Capillary Refill Time	***>3***
Pain	9/10 chest discomfort

Physical Assessment Findings	
Glasgow Coma Scale Score	14
Level of Consciousness	Alert
Heart Sounds	***Irregularly regular***
Lungs Sounds	Clear bilaterally anterior/posterior
Pulses-Radial	***Rapid/bounding***
Pulses-Pedal	***Weak***
Bowel Sounds	Present and active x 4
Edema	Trace bilateral lower extremities
Skin	Cool, clammy

2. Indicate whether the actions are “Indicated” (i.e., appropriate or necessary), “Contraindicated” (i.e., could be harmful), or “Nonessential” (i.e., makes no difference or are not necessary).

Nursing Action	Indicated	Contraindicated	Nonessential
Apply oxygen at 2 liters per nasal cannula.	X		
Call imagining for a STAT lung CT.			X
Perform the National Institutes of Health (NIH) Stroke Scale Neurologic Exam.			X
Obtain a comprehensive metabolic panel (CMP).	X		
Obtain a STAT EKG.	X		
Raise head-of-bed to less than 10 degrees.		X	
Establish patent IV access.	X		
Administer potassium 20 mEq IV push STAT.		X	

Answers to interactive elements are given within the interactive element.

Chapter 3

Answer Key to Chapter 3 Learning Activities

1. The answers to this activity are meant to elicit self-reflection in students as they consider the rights of delegation. Students should identify breach in right task, person, circumstance, communication, and supervision as they consider the errors in delegation within the case study scenarios.
2. The RN is delegating tasks to the LPN and UAP on a medical-surgical unit. Place an “X” in the appropriate column where an error in delegation occurred.

	Right Person	Right Task	Right Circumstances	Right Direction and Communication	Right Supervision and Evaluation
Directs the UAP to assess the pain level of a post op Day 3 hip replacement client and report back the finding.	x	x			
Directs the LPN to give 1 mg IV push morphine to a client who is 2-hours post total left knee replacement and ensure documentation.	x	x	x		
Assigns the UAP to collect blood pressures on all clients on the unit by 0800. Assumes the UAP will report back any abnormal blood pressures.				x	x
Directs a new UAP to ambulate a client who is post-op Day 2 from a shoulder replacement who needs the assistance of one person and an adaptive walker. The UAP voices concerns about never having used an adaptive walker before. The RN directs the UAP to get another UAP to help.					x

Answers to interactive elements are given within the interactive element.

Chapter 4

Answer Key to Chapter 4 Learning Activities

4.2 Leader vs. Manager Case Analysis

Case 1: Manager – *Sima's tasks involve allocating resources, making assignments, and handling staffing needs, which are all core management functions related to budgeting and staffing.*

Case 2: Leader – *Juan focuses on establishing direction, identifying issues requiring change, and creating a shared vision, all of which are leadership functions. He also implements strategies and inspires his team, which further emphasizes his role as a leader.*

Case 3: Manager – *Maria's activities involve planning, organizing, and prioritizing, which are essential management functions. Setting goals, establishing time frames, and creating policies and procedures are typical responsibilities of a manager.*

Case 4: Manager – *Emily's responsibilities, such as budgeting, resource allocation, and managing staffing needs, are core management functions. These tasks involve planning and organizing to ensure operational efficiency.*

Case 5: Leader – *Rachel's focus on building effective teamwork, advocating for clients and the nursing profession, and open communication aligns with leadership functions. These activities emphasize influencing others and fostering a collaborative environment.*

4.2 Just Culture Case Study

Case Investigation A

Classification of Error:

- Systemic Error (Design Flaw in Labeling)

Recommended Actions:

1. Report the Labeling Issue: Communicate with the insulin vial manufacturer about the confusing labeling and request a redesign to enhance clarity.
2. Labeling Review Committee: Establish a committee to review all medication labeling for potential confusion and initiate changes if necessary.
3. Training and Awareness: Conduct training sessions to educate nursing staff about the new labeling and interim measures to avoid confusion.
4. Double-Check Protocol Reinforcement: Reinforce the importance of adhering to double-check protocols, especially when using newly designed medication vials.
5. Incident Reporting System Enhancement: Enhance the incident reporting system to capture and analyze trends related to medication errors and implement preventive measures.

Case Investigation B

Classification of Error:

- Human Error (Due to Time Pressure and High Workload)

Recommended Actions:

1. Workload Assessment: Conduct a thorough assessment of the nursing workload and staffing levels to ensure they are adequate for safe client care.
2. Time Management Training: Provide training for nursing staff on time management strategies to handle high client loads without compromising safety protocols.
3. Staffing Solutions: Explore staffing solutions such as hiring additional staff, using float pools, or employing temporary nurses during peak times.
4. Protocol Reinforcement: Reinforce the importance of following safety protocols regardless of time pressures and workloads.
5. Supportive Environment: Create a supportive environment that encourages nurses to follow protocols without fear of repercussions for

taking necessary time to ensure client safety.

Case Investigation C

Classification of Error:

- Reckless Behavior (Intentional Bypassing of Safety Protocols)

Recommended Actions:

1. Disciplinary Action: Take appropriate disciplinary action against the nurse for knowingly disregarding safety protocols, which may include suspension, retraining, or termination depending on the severity and frequency of the behavior.
2. Behavior Monitoring: Implement a system to monitor and review the behavior of nurses to ensure adherence to safety protocols.
3. Retraining Program: Mandate a retraining program for the nurse to emphasize the importance of safety protocols and the consequences of non-compliance.
4. Culture of Safety: Foster a culture of safety within the hospital where following protocols is non-negotiable and staff feel accountable for their actions.
5. Counseling and Support: Provide counseling and support for the nurse to address any underlying issues contributing to the reckless behavior.

4.5 Learning Activity Sample Scenario

1-3. This learning activity is meant to elicit students' reflection on leadership styles, coaching, and change theory. Responses and application will vary.

Answers to interactive elements are given within the interactive element.

Chapter 5

Answer Key to Chapter 5 Learning Activities

Section 5.4 Professional Misconduct Case Study

1. Identify the ethical and legal issues present in this case.

Ethical Issues:

- *Non-maleficence: Sarah's primary duty is to do no harm to her clients. Administering the wrong medication dosage directly violated this principle.*
- *Fidelity: By not reporting the error and altering the medical records, Sarah violated the principle of fidelity, which emphasizes honesty and integrity in professional practice.*
- *Accountability: Nurses are ethically required to be accountable for their actions. Failing to report the medication error and falsifying records shows a lack of accountability.*

Legal Issues:

- *Negligence/Malpractice: Administering the wrong dosage of medication constitutes negligence, which can lead to malpractice claims.*
- *Falsification of Records: Altering medical records is a serious legal violation that can result in criminal charges and civil liabilities.*
- *Failure to Report: Not reporting a medication error is a breach of legal and professional duties, potentially leading to disciplinary actions by regulatory bodies.*

2. How does Sarah's behavior constitute professional misconduct?

- *She failed to adhere to established medication administration protocols by not double-checking the doctor's orders.*
- *She compromised client safety by administering the wrong medication dosage.*

- *She attempted to cover up her mistake by falsifying medical records, which is a severe breach of ethical and legal standards.*
- *She failed to report the medication error, preventing appropriate corrective actions from being taken and further endangering the client.*

3. What are the potential consequences for Sarah, both professionally and legally?

Professional Consequences: Sarah could face disciplinary measures from the nursing board, including suspension or revocation of her nursing license. She might be terminated from her job due to her actions. Her professional reputation could be severely damaged, making it difficult to find future employment in the healthcare field.

Legal Consequences: Mr. Thompson or his family could file a malpractice lawsuit against Sarah, seeking compensation for the harm caused. Altering medical records is a criminal offense that could result in charges, leading to fines or imprisonment. Sarah could face civil penalties for her negligence and falsification of records.

4. How might the lack of adequate staffing and supervision have contributed to this incident?

Understaffing led to Sarah handling multiple clients at once, increasing the likelihood of errors due to the high workload and stress. Lack of adequate supervision might have left Sarah without the necessary support and guidance, contributing to her mistake and poor decision-making. The urgent call to assist another critical client likely pressured Sarah to act hastily, bypassing essential safety checks.

5. What policies should the hospital have in place to prevent such errors and ensure proper reporting?

Ensure sufficient staffing levels to reduce workload and stress, allowing nurses to follow protocols without rushing. Implement and enforce strict protocols for medication administration, including mandatory double-

checking and verification processes. Establish non-punitive error reporting systems that encourage staff to report mistakes without fear of retribution, promoting a culture of transparency and learning. Provide ongoing training for staff on medication safety, error prevention, and ethical practices. Ensure adequate supervision and support for nurses, especially during busy or understaffed shifts.

6. How did Sarah's actions affect Mr. Thompson's safety and overall outcome?

Mr. Thompson's condition worsened significantly due to the wrong medication dosage, directly affecting his health and requiring intensive care. The failure to report the error delayed appropriate medical intervention, further compromising Mr. Thompson's safety and overall outcome. The altered medical records could have led to further incorrect treatments or misdiagnoses, increasing the risk to Mr. Thompson's health.

7. What impact might this incident have on the trust between healthcare professionals and clients?

Clients rely on health care professionals to provide safe and honest care. Incidents like this erode client trust in their caregivers and the health care system as a whole. Clients might become reluctant to seek care or follow medical advice, fearing potential errors and lack of transparency. Such incidents can damage the trust and collaboration among healthcare professionals, leading to a less cohesive and effective team dynamic.

End of Chapter Learning Activities

1. *This learning activity is meant to elicit students' reflection on legal implications of nursing practice. Students should identify issues related to nurse fatigue, client assignment, medication administration, staff education, etc., as areas of potential error. They should discuss the actions that were taken by the nurse in the case, different alternatives to the actions that were taken, reflection on how this case might impact their own nursing practice, and considerations regarding their belief of culpability of others (organization and other staff) in the case with supporting rationale.*

Answers to interactive elements are given within the interactive element.

Chapter 6

Answer Key to Chapter 6 Learning Activities

Case A & B

These learning activity case studies are meant to elicit students' reflection on ethical implications of nursing practice and client care. Students and instructors should recognize that there are a wide variety of ethical considerations when examining the case studies. They are meant to invoke discussion and critical thought.

Answers to interactive elements are given within the interactive element.

7.6 Team Qualities Case Application

Team Success Strategies:

Dr. Patel (Primary Physician): Dr. Patel consults with Chris (physical therapist) and Emily (speech therapist) before making any changes to Mary's medication that might affect her therapy sessions. This demonstrates collaboration and respect for other team members' expertise. Actively participates in scheduled interdisciplinary team meetings to discuss Mary's progress and adjust her care plan.

Chris (Physical Therapist) and Emily (Speech Therapist): Chris and Emily coordinate their therapy schedules to maximize Mary's participation and avoid conflicting sessions and fatigue. This shows effective teamwork and prioritization of client-centered care. Engage in interdisciplinary team meetings, contributing to discussions and adjustments in Mary's care plan.

Individuals Lacking Demonstration of Team Strategies:

Laura (Social Worker): Struggles to include Mary's family in discharge planning discussions but moves forward with client placement paperwork independently. How to Modify Approach: Make a concerted effort to involve Mary's family in discharge planning discussions, perhaps by scheduling family meetings or using video conferencing if the family cannot be present. Actively seek feedback from Mary and her family regarding their preferences and needs for discharge planning to ensure the chosen facility is acceptable to all parties. Share concerns and discuss discharge plans in interdisciplinary meetings to gather input and support from other team members.

Lisa (Dietitian): Identifies a dietary plan that she believes will best meet Mary's nutritional needs but disregards Mary's dietary preferences. How to Modify Approach: Work to incorporate Mary's dietary preferences into the nutritional plan to ensure it is both effective and acceptable to Mary.

Engage in discussions with Mary and her family about dietary preferences and restrictions, explaining the importance of certain nutritional choices while finding a balance that meets Mary's needs and preferences. Discuss the dietary plan and any challenges in interdisciplinary meetings to get insights and support from other team members who may offer additional strategies for addressing dietary concerns.

End of Chapter Learning Activities

Please access the following link to explore the embedded TeamSTEPPS® activities:

- TeamSTEPPS® Instructor Manual: Specialty Scenarios.

Answers to interactive elements are given within the interactive element.

8.2 Case Study Maria's Journey Through the Health Care System

1. Maria's financial stress can lead to poor medication adherence, unhealthy dietary choices, and infrequent medical visits. This results in poorly controlled diabetes and increased risk of complications. Additionally, the constant stress of managing her finances can raise cortisol levels, negatively impacting her blood sugar control.

2. Programs such as sliding scale fees at clinics, subsidies for medications, food assistance programs like SNAP, and community-based health initiatives could help reduce the financial burden on individuals like Maria. Expanding Medicaid and implementing prescription drug assistance programs are also effective measures.

3. Improved health literacy can empower Maria to understand her condition better, follow her treatment plan accurately, make healthier lifestyle choices, and seek timely medical help. This knowledge can lead to better diabetes control, fewer complications, and overall improved health outcomes.

4. Community health workshops, educational programs at local community centers, partnerships with local schools to provide health education, and accessible online resources can enhance health education. These programs should focus on diabetes self-management, nutrition, and general health literacy.

5. The lack of accessible health care services can lead to delayed treatment, worsening of Maria's condition, increased complications, and ultimately higher health care costs due to emergency care and hospitalizations. Poor access to health care also reduces preventive care opportunities, contributing to the progression of chronic diseases like diabetes.

6. Solutions include expanding community health centers, providing mobile health clinics, increasing funding for public health initiatives, and implementing telehealth services to reach underserved populations. Additionally, policies that incentivize health care providers to work in

underserved areas and improving public transportation to healthcare facilities can help.

7. Living in a food desert forces Maria to consume high-calorie, low-nutrient foods, which can lead to poor diabetes control and increased complications. Limited access to healthy foods makes it challenging to follow dietary recommendations for managing diabetes.

8. Initiatives could include improving public transportation routes, providing subsidized transportation vouchers, partnering with ride-sharing services, and developing community-based transport programs. Mobile clinics and telehealth services can also mitigate transportation barriers by bringing healthcare services directly to the community.

9. A lack of social support can lead to feelings of isolation, depression, and reduced motivation to adhere to treatment plans. Social support is crucial for emotional well-being and effective disease management. Without it, Maria may struggle more with managing her diabetes and overall health.

10. Community programs such as neighborhood watch groups, community centers offering social activities, mental health support groups, and safe spaces for exercise can enhance social support and safety. Initiatives to improve public safety, such as increased police presence and community policing, can also create a safer environment for residents to engage in outdoor activities and social interactions.

Answers to interactive elements are given within the interactive element.

Chapter 9

Answers to interactive elements are given within the interactive element.

Chapter 10

Answers to interactive elements are given within the interactive element.

Chapter 11

Answers to interactive elements are given within the interactive element.

Chapter 12

Answers to interactive elements are given within the interactive element.

Exercises

Utilize the “Suite of Patients” and suggested prompt activities below to engage your students in knowledge application associated with the various learning units throughout the text.

Clients on the Inpatient Unit

1. 56-year-old female admitted yesterday afternoon with nausea/vomiting and right-sided upper abdominal pain that increases after eating. Has had two stools since admit and vomiting stopped after dose of Zofran in ER. Had ERCP yesterday afternoon for dilated biliary duct. She is scheduled for OR this morning for cholecystectomy. Only medical history is depression and surgical history of C-section x2. She does not take any medications routinely at home. She is accompanied by her 17-year-old daughter.
2. 65-year-old male hospitalized three days prior with malaise, cough, cachexia, and 30 pounds of unintentional weight loss over past six weeks. He has a remote history of alcohol and drug abuse but has been sober for more than 10 years. He was diagnosed with acquired immunodeficiency syndrome (AIDS), pneumocystis pneumonia (PCP), and oral candidiasis. He is being treated with IV fluids, IV Bactrim, and IV fluconazole. He is divorced and has one daughter. His ex-wife came to the hospital yesterday to visit. He has no visitors currently. The client is very quiet and withdrawn.
3. 32-year-old nonbinary person, who was transferred from the ICU this morning after being extubated. Client was admitted five days prior with COVID. Client cannot have visitors due to

COVID status. Continues four liters nasal cannula oxygen.

4. 29-year-old female with cellulitis on right arm from infiltration from heroine injection. Her wife is present, along with their 4-year-old son. She had an I&D yesterday and may need to have repeat procedure tomorrow. Currently on IV antibiotics.
5. 52-year-old male with gangrene of fourth toe from having a nail through sole of shoe. Client has a history of uncontrolled diabetes, hypertension (HTN), peripheral vascular disease (PVD), chronic kidney disease (CKD) stage 2, and peripheral neuropathy. Receiving IV antibiotics and scheduled for toe amputation tomorrow. He has no visitors.
6. 82-year-old female who had elective right hip replacement for uncontrolled hip pain and degenerative joint disease (DJD). She has a history of type 2 diabetes mellitus on metformin and dietary restrictions; previous hysterectomy, osteoporosis, carpal tunnel repair, and rheumatoid arthritis, which she takes oral methotrexate to control. She has a son who is visiting. Expected to be discharged today.
7. 68-year-old male awaiting nursing home placement following admission for hepatic encephalopathy from alcoholism. He was medically cleared last week but is a registered sex offender and has yet to find placement. He has an activated power of attorney, who is a state-appointed guardian. He continues to get up without calling, makes inappropriate remarks to staff, and had a fall three days prior. Other history is bipolar disorder, alcohol abuse, type 2 diabetic, chronic kidney disease stage 3, and hypertension.
8. 19-year-old female admitted for what is presumed Benadryl overdose last evening. On room air, needs to have 1:1 sitter present. Client is not responding to questions; does not know if this is accidental overdose or intentional. History of previous

intentional overdose, depression, and anxiety. Dad is present and demanding to know if a toxicology screen was completed and what it showed.

9. 61-year-old male admitted six days prior with confusion. Was found by a neighbor wandering. Works at the local gas station. Initial work up shows what appears to be lung cancer with brain metastasis. Client does not have a power of attorney. He is not married and is estranged from his son. Neighbor who found him is a friend and is willing to become guardian. History from neighbor and review of medical records shows a history of smoking. Neighbor says it does appear he has lost weight recently but hadn't mentioned other concerns when he had talked to him about two weeks ago. In the process of paperwork to be completed for guardianship. Client had been aspirating when eating; decision to start nasal gastric feed was made yesterday by ethics committee. Awaiting guardianship for further decision on biopsy for confirmed diagnoses and decision to proceed with treatment or switch to hospice care.
10. 45-year-old female admitted last evening who is short of breath, dizzy, light-headed, and gastrointestinal bleed. Esophagogastroduodenoscopy (EGD) scheduled for this morning. If negative, will need prep for colonoscopy and then colonoscopy tomorrow. Client has little medical history except had recently returned from an overseas trip and had chest and back pain about two days after returning. Had been found to have a saddle PE and was hospitalized for five days on heparin drip and discharged home with coumadin about a week prior. Client continued to have back and intermittent chest pain and had been taking ibuprofen 1-2 times daily since discharge. Husband brought her in last night when she was found to have a Hgb of 6.2. Husband is

furious that no one told them she should not be taking ibuprofen on previous discharge.

11. 64-year-old male with BKA for nonhealing diabetic ulcer; scheduled to go to rehab today if bed becomes available. Lives alone in a second floor, low-income apartment without an elevator. Does not have any visitors.
12. 32-year-old male admitted 15 days prior for newly diagnosed AML. Received induction therapy starting 13 days ago. Client is at nadir, will need 1 unit of PRBCs for a Hgb of 6.2 today and a unit of platelets for a platelet count of 8. Client has had fevers for the past two days and is currently receiving vancomycin and cefepime. Also, on prophylactic acyclovir and fluconazole. Client has mucositis and is on PCA pump and receiving TPN and diet as tolerated (magic mouthwash before meals).
13. Cachexic 25-year-old female with history of cystic fibrosis. Admitted for CF exacerbation overnight. Eats during the day and is tube fed overnight. Admitted for extensive pulmonary toileting, IV antibiotics (tobramycin and cefuroxime), continued home respiratory treatments. Client also needs to have nutrition recommendations reviewed during this hospitalization. She is here with her boyfriend. The boyfriend also has two school-aged children who would like to visit.
14. 78-year-old male with a history of HTN and hypothyroid. Admitted two days prior to abdominal pain and nausea/vomiting. Had a colectomy yesterday for perforated diverticulitis. Client is NPO and has NG tube in place. Had nausea overnight. His wife is expected to visit later today; she went home after return from OR yesterday.
15. 89-year-old female admitted from nursing home yesterday with increased confusion. Has a history of dementia, HTN, type 2 diabetes, and dysphagia. Was found to have a UTI.

Started on IV Levaquin; awaiting urine cultures. Expected discharge tomorrow. She has been trying to get up frequently overnight. No family present. Needs 1:1 supervision for all feedings.

16. 82-year-old man admitted with COPD exacerbation and is on 2 L of home oxygen baseline. Oxygen saturation was 78% on arrival and has not been able to do ADLs because of shortness of breath. Has CAD, HTN, and PAD. Lives in a duplex with his granddaughter who lives on the other side. His granddaughter called yesterday.
17. 68-year-old male who is morbidly obese and admitted two days prior for shortness of breath with CHF. Client is on IV bumex and is down 25 pounds since admit. He has a history of HTN, CAD, post CABG, and CKD stage 2. Expected discharge today.
18. 36-year-old female admitted for excessive uterine bleeding four days prior. Newly diagnosed with uterine cancer. Client had open hysterectomy, oophorectomy, salpingotomy, and lymph node biopsy. Had diagnostics, port placement, and staging over the past three days. Expected discharge today. Her husband is here with their 16-month-old daughter. The husband has been very inattentive during this hospitalization and has expected her to watch their daughter over the last couple days and even left to go for lunch yesterday while leaving the daughter in the room.
19. 68-year-old male with history of stage 3 CKD and admitted with AKI on CKD yesterday. Client has had nausea and vomiting for past 36 hours; baseline creatinine of 1.8 and was 4.6 on admit. Has been given fluid hydration and is down to 3.2 this morning.
20. Bed open.
21. It is “ortho day” in the OR. There are three clients scheduled. 1

is a 54-year-old male with bilateral knee replacement (0800 surgery time) and scheduled for observation admit. 68-year-old women with right knee (1100 surgery time) and expected to be discharged. 78-year-old male with hip replacement (1300 OR time) and scheduled for observation admit.

22. 72-year-old female waiting for a bed in the emergency room. Arrived overnight with hypoxia, cough, SOB. Positive for influenza.

Classroom Activity Ideas:

Prioritization

Put students in groups and a client assignment (4-5 clients). Have them identify who they would see first, second, etc. Why?

Students will review all of the clients on the unit. Have them identify those who are most critical and why.

Add in "changes of conditions" – Client with AKI on CKD morning labs showed a K of 7.2 and Na of 118. AML spikes temp of 103.6 and develops hives and chest tightness when PRBCs are infusing. Client with newly diagnosed uterine cancer states she is concerned going home with her husband because she feels the abuse is going to get worse now that she is sick.

Classroom Activity Ideas:

Delegation/Supervision

Different staffing assignments: 5 RNs/2 CNAs; 4 RNS, 2 LPNs, 2 CNAs; charge nurse/no change nurse. Have students identify appropriate assignments, tasks for delegation, etc.

Consider different types of acute care units – would you organize assignments differently?

Classroom Activity Ideas:

Legal

Develop a scenario in which one client is upset about not being taught about ibuprofen. Consider the legal implications associated with the lack of education.

How would a student address the father who wants to get information on daughter who overdosed?

Can a 17-year-old daughter be at the hospital without another guardian?

Classroom Activity Ideas:

Economics

Talk about isolation/PPE use and staffing ratios.

Have students utilize a couple different staffing tools to see acuity score.

Classroom Activity Ideas:

Quality/Evidence-Based Practice

Have students look up EBP guideline on one of their clients in their assignment (e.g., when to transfuse with blood and platelets for AML client, ERCP prior to cholecystectomy, etc.).

Classroom Activity Ideas:

Ethical Practice

Client who is waiting guardianship placement – diagnosed with new brain tumor.

Classroom Activity Ideas:

Managing the Nursing Team

Talk about the ways a charge nurse, nurse manager, and RN work with these clients.

Have each team assigned a new client (post op, one in ED) with different methods of assigning – choosing who the new client for the day would be, assigning at start of shift, and during the day.

Have one of the nurses refuse a new client.

Classroom Activity Ideas:

Collaborating with Multidisciplinary Team

With your assigned clients, whom would you interact with during the day (e.g., PT, OT, ST, provider, lab, case management)?

Classroom Activity Ideas:

Advocacy

What community agencies might you recommend to the clients with whom you are working?

How would you work with a client (e.g., the hip client #6) who doesn't feel comfortable being discharged today?

A

ABCs: Airway, breathing, and circulation. (Chapter 2.3)

Accountability: Being answerable to oneself and others for one's own choices, decisions, and actions as measured against a standard. (Chapter 3.4)

Accreditation: A review process to determine if an agency meets the defined standards of quality determined by the accrediting body. (Chapter 9.2)

Actual problems: Nursing problems currently occurring with the client. (Chapter 2.3)

Acuity: The level of client care that is required based on the severity of a client's illness or condition. (Chapter 2.3)

Acuity-based staffing: A client assignment model that takes into account the level of client care required based on the severity of a client's illness or condition. (Chapter 8.5)

Acuity-rating staffing models: A staffing model used to make client assignments that reflects the individualized nursing care required for different types of clients. (Chapter 2.3)

Acute conditions: Conditions having a sudden onset. (Chapter 2.3)

Administrative law: Law made by government agencies that have been granted the authority to pass rules and regulations. For example, each state's Board of Nursing is an example of administrative law. (Chapter 5.2)

Admission: Refers to an initial visit or contact with a client. (Chapter 7.8)

Advanced directives: Written instruction, such as a living will or durable

power of attorney for health care, recognized under state law, relating to the provision of health care when the individual is incapacitated. (Chapter 5.6)

Advocacy: The act or process of pleading for, supporting, or recommending a cause or course of action. Advocacy may be for persons (whether an individual, group, population, or society) or for an issue, such as potable water or global health. (Chapter 6.2, Chapter 10.2)

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. (Chapter 8.2)

ANA's Standards of Professional Practice: Standards describing a competent level of nursing practice as demonstrated by the critical thinking model known as the nursing process. The nursing process includes the components of assessment, diagnosis, outcomes identification, planning, implementation, and evaluation. (Chapter 1.1)

ANA's Standards of Professional Performance: Standards describing a competent level of behavior in the professional nursing role, including activities related to ethics, advocacy, respectful and equitable practice, communication, collaboration, leadership, education, scholarly inquiry, quality of practice, professional practice evaluation, resource stewardship, and environmental health. (Chapter 1.1, Chapter 9.2)

Assault: Intentionally putting another person in reasonable apprehension of an imminent harmful or offensive contact. (Chapter 5.2)

Assignment: Routine care, activities, and procedures that are within the authorized scope of practice of the RN, LPN/VN, or routine functions of the assistive personnel. (Chapter 3.3)

Autonomy: The capacity to determine one's own actions through independent choice, including demonstration of competence. (Chapter 6.2)

B

Battery: Intentional causation of harmful or offensive contact with another's person without that person's consent. (Chapter 5.2)

Beneficence: The bioethical principle of benefiting others by preventing harm, removing harmful conditions, or affirmatively acting to benefit another or others, often going beyond what is required by law. (Chapter 6.2)

Benner's Novice to Expert Theory: A theory by Dr. Patricia Benner that explains how new hires develop skills and a holistic understanding of client care over time, resulting from a combination of a strong educational foundation and thorough clinical experiences. Benner's theory identifies five levels of nursing experience: novice, advanced beginner, competent, proficient, and expert. (Chapter 11.5)

Board of Nursing: The state-specific licensing and regulatory body that sets standards for safe nursing care and issues nursing licenses to qualified candidates, based on the Nurse Practice Act. (Chapter 1.1)

Brief: A short session to share a plan, discuss team formation, assign roles and responsibilities, establish expectations and climate, and anticipate outcomes and contingencies. (Chapter 7.6)

Budget: An estimate of revenue and expenses over a specified period of time, usually over a year. (Chapter 8.5)

Burnout: A condition manifested physically and psychologically with a loss of motivation. (Chapter 12.6)

C

Capacity: A functional determination that an individual is or is not capable of making a medical decision within a given situation. (Chapter 5.6)

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. (Chapter 8.5)

Change: The process of altering or replacing existing knowledge, skills, attitudes, systems, policies, or procedures. (Chapter 4.3)

Change agent: Anyone who has the skill and power to stimulate, facilitate, and coordinate the change effort. (Chapter 4.3)

Change management: Process of making changes in a deliberate, planned, and systematic manner. (Chapter 4.3)

Chronic conditions: Conditions that have a slow onset and may gradually worsen over time. (Chapter 2.3)

Civil law: Law focusing on the rights, responsibilities, and legal relationships between private citizens. (Chapter 5.2)

Clinical reasoning: "A complex cognitive process that uses formal and informal thinking strategies to gather and analyze client information, evaluate the significance of this information, and weigh alternative actions." (Chapter 2.4)

Closed-loop communication: A communication strategy used to ensure that information conveyed by the sender is heard by the receiver and completed. (Chapter 3.2, Chapter 7.5)

Code of ethics: A set of ethical principles established by a profession that is designed to govern decision-making and assist individuals to distinguish right from wrong. (Chapter 6.2)

Collective bargaining: Negotiation of wages and other conditions of employment by an organized body of employees. (Chapter 10.4)

Commission: Doing something a reasonable nurse would not have done. (Chapter 5.2)

Communication conflict: Occurs when there is a failure in the exchange of information. (Chapter 7.7)

Compassion fatigue: A state of chronic and continuous self-sacrifice and/or prolonged exposure to difficult situations that affect a health care professional's physical, emotional, and spiritual well-being. (Chapter 12.6)

Competence: In a legal sense, the ability of an individual to participate in legal proceedings. A judge decides if an individual is "competent" or "incompetent." (Chapter 5.6)

Confidentiality: The right of an individual to have personal, identifiable medical information kept private. (Chapter 5.2)

Consequentialism: An ethical theory used to determine whether or not an action is right by the consequences of the action. For example, most people agree that lying is wrong, but if telling a lie would help save a person's life, consequentialism says it's the right thing to do. (Chapter 6.2)

Constitutional law: The rights, privileges, and responsibilities established by the U.S. Constitution. For example, the right to privacy is a right established by the constitution. (Chapter 5.2)

Constructive feedback: Supportive feedback that offers solutions to areas of weakness. (Chapter 3.5)

Continuity of care: The use of information on past events and personal circumstances to make current care appropriate for each individual. (Chapter 7.8)

Contracts: Binding written, verbal, or implied agreements. (Chapter 5.2)

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. (Chapter 8.3)

Core measures: National standards of care and treatment processes for common conditions. These processes are proven to reduce complications and lead to better client outcomes. (Chapter 9.2)

Core values: The foundational ideals that guide the organization's actions and decision-making processes. (Chapter 4.2)

Crime: A type of behavior defined by Congress or state legislature as deserving of punishment. (Chapter 5.2)

Criminal law: A system of laws concerned with punishment of individuals who commit crimes. (Chapter 5.2)

Critical thinking: A broad term used in nursing that includes "reasoning about clinical issues such as teamwork, collaboration, and streamlining workflow." (Chapter 2.4)

Cultural diversity: A term used to describe cultural differences among clients, family members, and health care team members. (Chapter 7.3)

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. (Chapter 6.2, Chapter 7.3)

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 client safety. Just Culture is a component of a culture of safety. (Chapter 4.2, Chapter 5.5))

CURE hierarchy: A strategy for prioritization based on identifying "critical" needs, "urgent" needs, "routine" needs, and "extras." (Chapter 2.3)

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 statements are “I am Concerned – I am Uncomfortable – This is a Safety issue!” (Chapter 7.6)

D

Data cues: Pieces of significant clinical information that direct the nurse toward a potential clinical concern or a change in condition. (Chapter 2.3)

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. (Chapter 7.6)

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. (Chapter 8.3)

Defamation of character: An act of making negative, malicious, and false remarks about another person to damage their reputation. Slander is spoken defamation and libel is written defamation. (Chapter 5.2)

Defendants: The parties named in a lawsuit. (Chapter 5.2)

Delegated responsibility: A nursing activity, skill, or procedure that is transferred from a license nurse to a delegatee. (Chapter 3.4)

Delegatee: An RN, LPN/VN, or AP who is delegated a nursing responsibility by either an APRN, RN, or LPN/VN who is competent to perform the task and verbally accepts the responsibility. (Chapter 3.4)

Delegation: Allowing a delegatee to perform a specific nursing activity, skill, or procedure that is beyond the delegatee’s traditional role but in which they have received additional training. (Chapter 3.4)

Delegator: An APRN, RN, or LPN/VN who requests a specially trained delegatee to perform a specific nursing activity, skill, or procedure that is beyond the delegatee's traditional role. (Chapter 3.4)

Deontology: An ethical theory based on rules that distinguish right from wrong. (Chapter 6.2)

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. (Chapter 7.6)

Discharge: The completion of care and services in a health care facility and the client is sent home (or to another health care facility). (Chapter 7.8)

Durable power of attorney for healthcare (DPOAHC): Person chosen to speak on one's behalf if one becomes incapacitated. (Chapter 5.6)

Duty of reasonable care: Legal obligations nurses have to their clients to adhere to current standards of practice. (Chapter 5.2)

E

Economics: The study of how society makes decisions about its limited resources. (Chapter 8.1)

Ethical conflict: Occurs when individuals or groups have fundamentally different beliefs and values. (Chapter 7.7)

Ethical dilemma: Conflict resulting from competing values that requires a decision to be made from equally desirable or undesirable options. (Chapter 6.3)

Ethical principles: Principles used to define nurses' moral duties and aid in ethical analysis and decision-making. Foundational ethical principles include autonomy (self-determination), beneficence (do good), nonmaleficence (do no harm), justice (fairness), and veracity (tell the truth). (Chapter 6.2)

Ethics: A system of moral principles that a society uses to identify right from wrong. (Chapter 6.2)

Ethics committee: A formal committee established by a health care organization to problem-solve ethical dilemmas. (Chapter 6.4)

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 client, family, group, community, and population preferences and values. (Chapter 8.4, Chapter 9.4, Chapter 10.7)

Expected conditions: Conditions that are likely to occur or anticipated in the course of an illness, disease, or injury. (Chapter 2.3)

Extrinsic factors: External elements that impact health care costs. (Chapter 8.2)

F

False imprisonment: An act of restraining another person causing that person to be confined in a bounded area. Restraints can be physical, verbal, or chemical. (Chapter 5.2)

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. (Chapter 7.6)

Felonies: Serious crimes that cause the perpetrator to be imprisoned for greater than one year. (Chapter 5.2)

Fidelity: An ethical principle meaning keeping promises. (Chapter 6.2)

Five rights of delegation: Right task, right circumstance, right person, right directions and communication, and right supervision and evaluation. (Chapter 3.4)

Floating: An agency strategy that asks nurses to temporarily work on a different unit to help cover a short-staffed shift. (Chapter 8.5)

Followership: The upward influence of individuals on their leaders and their teams. (Chapter 4.2)

Fraud: An act of deceiving an individual for personal gain. (Chapter 5.2)

G

Goal conflict: Happens when the objectives of individuals or groups are incompatible. (Chapter 7.7)

Good Samaritan Law: State law providing protections against negligence claims to individuals who render aid to people experiencing medical emergencies outside of clinical environments. (Chapter 5.2)

Grievance process: A process for resolving disagreements between employees and management. (Chapter 10.4)

H

Handoff reports: A transfer and acceptance of client care responsibility achieved through effective communication. It is a real-time process of passing client 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 client's care. (Chapter 7.5)

Harmful stress: Stress (also referred to as "distress") not adequately self-managed resulting in physical, mental, and behavioral consequences. (Chapter 12.3)

Health care disparity: Differences in access to health care and insurance coverage. (Chapter 8.4)

Health disparities: Differences in health outcomes that result from social determinants of health (SDOH). (Chapter 8.4)

Horizontal aggression: Hostile behavior among one's peers. (Chapter 7.7)

Huddle: A brief meeting during a shift to reestablish situational awareness, reinforce plans already in place, and adjust the teamwork plan as needed. (Chapter 7.6)

I

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 client 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. (Chapter 7.6)

Informatics: Using information and technology to communicate, manage

knowledge, mitigate error, and support decision-making. This allows members of the health care team to share, store, and analyze health-related information. (Chapter 9.3, Chapter 10.7)

Informed consent: The fundamental right of a client to accept or reject health care. (Chapter 5.6)

Infractions: Minor offenses, such as speeding tickets, that result in fines but not jail time. (Chapter 5.2)

Institutional liability: When the healthcare institution (e.g., hospital, clinic) is held responsible for the actions of its employees or for failing to implement adequate policies and procedures to prevent harm. (Chapter 5.3)

Institutional Review Board (IRB): A group that has been formally designated to review and monitor biomedical research involving human subjects. (Chapter 6.4)

Intentional tort: An act of commission with the intent of harming or causing damage to another person. Examples of intentional torts include assault, battery, false imprisonment, slander, libel, and breach of privacy or client confidentiality. (Chapter 5.2)

Interdisciplinary care conferences: Meetings where interprofessional team members professionally collaborate, share their expertise, and plan collaborative interventions to meet client needs. (Chapter 7.8)

Interprofessional collaborative practice: Multiple health workers from different professional backgrounds working together with clients, families, caregivers, and communities to deliver the highest quality of care. (Chapter 7.1)

Intrinsic factors: Factors that are inherent to the characteristics and needs of the population. (Chapter 8.2)

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. (Chapter 7.5)

ISBARR: A mnemonic for the components to include when communicating with another health care team member: Introduction, Situation, Background, Assessment, Request/Recommendations, and Repeat back. (Chapter 7.5, Chapter 10.7)

J

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. (Chapter 4.2)

Justice: A moral obligation to act on the basis of equality and equity and a standard linked to fairness for all in society. (Chapter 6.2)

L

Laws: Rules and regulations created by society and enforced by courts, statutes, and/or professional licensure boards. (Chapter 5.2)

Leadership: The art of establishing direction and influencing and motivating others to achieve their maximum potential to accomplish tasks, objectives, or projects. (Chapter 4.2)

Libel: Written defamation. (Chapter 5.2)

Licensure: The process by which a State Board of Nursing (SBON) grants permission to an individual to engage in nursing practice after verifying the

applicant has attained the competency necessary to perform the scope of practice of a registered nurse (RN). The SBON verifies three components:

- Verification of graduation from an approved prelicensure RN nursing education program
- Verification of successful completion of NCLEX-RN examination
- A criminal background check (in some states) (Chapter 11.3)

Living will: A type of advance directive in which an individual identifies what treatments they would like to receive or refuse if they become incapacitated and unable to make decisions.

M

Magnet® Recognition Program: An organizational credential that recognizes quality client outcomes, nursing excellence, and innovations in professional nursing practice. (Chapter 10.4)

Malpractice: A specific term used for negligence committed by a professional with a license. (Chapter 5.2)

Management: Roles that focus on tasks such as planning, organizing, prioritizing, budgeting, staffing, coordinating, and reporting. (Chapter 4.2)

Mandatory overtime: A requirement by agencies for nurses to stay and care for clients beyond their scheduled shift when short staffing occurs. (Chapter 8.5)

Maslow's Hierarchy of Needs: Prioritization strategies often reflect the foundational elements of physiological needs and safety and progress toward higher levels. (Chapter 2.3)

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. (Chapter 8.3)

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. (Chapter 8.3)

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. (Chapter 9.4)

Mindfulness: Awareness that arises through paying attention, being on purpose and in the present moment, and being nonjudgmental. (Chapter 12.6)

Misdemeanors: Less serious crimes resulting in fines and/or imprisonment for less than one year. (Chapter 5.2)

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. (Chapter 4.2)

Moral conflict: Feelings occurring when an individual is uncertain about what values or principles should be applied to an ethical issue. (Chapter 6.3)

Moral courage: The willingness of an individual to speak out and do what is right in the face of forces that would lead us to act in some other way. (Chapter 6.3)

Moral distress: Feelings occurring when correct ethical action is identified but the individual feels constrained by competing values of an organization or other individuals. (Chapter 6.3)

Moral injury: The distressing psychological, behavioral, social, and sometimes spiritual aftermath of exposure to events that contradict deeply held moral beliefs and expectations. (Chapter 6.3)

Morality: Personal values, character, or conduct of individuals or groups within communities and societies. (Chapter 6.2)

Moral outrage: Feelings occurring when an individual witnesses immoral acts or practices they feel powerless to change. (Chapter 6.3)

Morals: The prevailing standards of behavior of a society that enable people to live cooperatively in groups. (Chapter 6.2)

Mutual support: The ability to anticipate and support team members' needs through accurate knowledge about their responsibilities and workload. (Chapter 7.6)

N

National 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. (Chapter 9.2)

NCLEX-RN: The exam that nursing graduates must pass successfully to obtain their nursing license and become a registered nurse. (Chapter 11.2)

NCLEX-RN Test Plan: A concise summary of the content and scope of the NCLEX that serves as an excellent guide for preparing for the exam. These plans are updated every three years based on surveys of newly licensed registered nurses to ensure the NCLEX questions reflect fair, comprehensive, current, and entry-level nursing competency. (Chapter 11.2)

Negligence: The failure to exercise the ordinary care a reasonable person would use in similar circumstances. Wisconsin civil jury instruction states, "A

person is not using ordinary care and is negligent, if the person, without intending to do harm, does something (or fails to do something) that a reasonable person would recognize as creating an unreasonable risk of injury or damage to a person or property." (Chapter 5.2)

Nonmaleficence: The bioethical principle that specifies a duty to do no harm and balances avoidable harm with benefits of good achieved. (Chapter 6.2)

Normal stress: Stress (also referred to as "eustress") that does not have lasting consequences and is successfully managed by the individual who is experiencing it. (Chapter 12.3)

Nurse Licensure Compact (NLC): State legislation that allows nurses to practice in other NLC states with their original state's nursing license without having to obtain additional licenses, contingent upon remaining a resident of that state. (Chapter 11.3)

Nurse Practice Act: Law enacted by a state's legislature that defines the scope of nursing practice and establishes regulations for nursing practice within that state. (Chapter 1.1)

Nurse residency programs: A transition process that provides additional professional development for newly licensed nurses. These programs vary from institution to institution, but many start around the time the new graduate ends their orientation with a preceptor and continue to provide routine support throughout the year. (Chapter 11.5)

Nursing: Integrates the art and science of caring and focuses on the protection, promotion, and optimization of health and human functioning; prevention of illness and injury; facilitation of healing; and alleviation of suffering through compassionate presence. Nursing is the diagnosis and treatment of human responses and advocacy in the care of individuals, families, groups, communities, and populations in recognition of the connection of all humanity." (Chapter 1.1)

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. (Chapter 9.3)

Nursing process: Includes the components of assessment, diagnosis, outcomes identification, planning, implementation, and evaluation. (Chapter 1.1)

Nursing research: The systematic inquiry designed to develop knowledge about issues of importance to the nursing profession. The purpose of nursing research is to advance nursing practice through the discovery of new information. It is also used to provide scholarly evidence regarding improved client outcomes resulting from nursing interventions. (Chapter 9.4)

Nursing team members: Advanced practice registered nurses (APRN), registered nurses (RN), licensed practical/vocational nurses (LPN/VN), and assistive personnel (AP). (Chapter 3.1)

O

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. (Chapter 8.5)

Omission: Not doing something a reasonable nurse would have done. (Chapter 5.2)

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. (Chapter 8.5)

Operating budgets: Budgets including personnel costs and annual facility operating costs. (Chapter 8.5)

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. (Chapter 4.2)

Orientation: A structured transition process when hired into a new position that may last from one to four months but can be longer depending on the specialty (e.g., Intensive Care or Labor and Delivery). Orientation is based on the new nurse's demonstration and completion of competencies. During this time the novice RN will work with a preceptor to experience all the aspects of the role. (Chapter 11.5)

P

Paternalism: The interference by the state or an individual with another person, defended by the claim that the person interfered with will be better off or protected from harm. (Chapter 6.2)

Patient-centered care: The client is the source of control and full partner in providing compassionate and coordinated care based on respect for clients preferences, values, and needs. (Chapter 10.7)

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. (Chapter 8.4)

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. (Chapter 9.4)

Personality conflict: Arises from differences in individual temperaments, attitudes, and behaviors. (Chapter 7.7)

Plaintiff: The person bringing the lawsuit. (Chapter 5.2)

Policy: An expected course of action set by an agency. (Chapter 1.1)

Portfolio: A compilation of materials showcasing examples of previous work demonstrating one's skills, qualifications, education, training, and experience. (Chapter 11.4)

Preceptors: Experienced and competent RNs who serve as a role model and a resource to a newly hired nurse. These nurses have the knowledge, skills, and the ability to coach the new RN into the nursing role and answer questions while also evaluating a new hire's performance and providing feedback for improvement. (Chapter 11.5)

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. (Chapter 9.4)

Private law: Laws that govern the relationships between private entities. (Chapter 5.2)

Procedure: An official way of completing a task. (Chapter 1.1)

Protected Health Information (PHI): Individually identifiable health information and includes demographic data related to the individual's past, present, or future physical or mental health or condition; the provision of health care to the individual; and the past, present, or future payment for the provision of health care to the individual. (Chapter 5.2)

Protocol: A detailed, written plan for performing a regimen of therapy. (Chapter 1.1)

Public law: Law regulating relations of individuals with the government or institutions. (Chapter 5.2)

Q

Qualitative studies: 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. (Chapter 9.4)

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. (Chapter 9.2)

Quality Improvement (QI): A systematic process using measurable data to improve health care services and the overall health status of clients. The QI process includes the steps of Plan, Do, Study, and Act. (Chapter 9.3, Chapter 10.7)

Quantitative studies: 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. (Chapter 9.4)

R

Ratio-based staffing models: A staffing model used to make client assignments in terms of one nurse caring for a set number of clients. (Chapter 2.3)

Resiliency training: Educational sessions that foster feelings of mindfulness and sensitivity to self and cultivate professional development techniques that contribute to long-term engagement in the profession. (Chapter 12.7)

Resource stewardship: Using appropriate resources to plan, provide, and sustain evidence-based nursing services that are safe, effective, financially responsible, and used judiciously. (Chapter 8.6)

Resume: A document that highlights one's background, education, skills, and accomplishments to potential employers. (Chapter 11.4)

Risk problem: A nursing problem that reflects that a client may experience a problem but does not currently have signs reflecting the problem is actively occurring. (Chapter 2.3)

Role conflict: Arises when individuals have multiple, often conflicting, expectations associated with their roles. (Chapter 7.7)

S

Scope of practice: Procedures, actions, and processes that a health care practitioner is permitted to undertake in keeping with the terms of their professional license. (Chapter 3.3)

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. (Chapter 9.4)

Self-care: Actions that individuals take to maintain health of oneself. (Chapter 12.6)

Shared governance: A shared leadership model between management and employees working together to achieve common goals. (Chapter 10.4)

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. (Chapter 7.6)

Situation awareness: The awareness of a team member knowing what is going on around them. (Chapter 7.6)

Situation monitoring: The process of continually scanning and assessing the situation to gain and maintain an understanding of what is going on around you. (Chapter 7.6)

Slander: Spoken defamation. (Chapter 5.2)

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. (Chapter 8.2, Chapter 8.4, Chapter 10.4)

Standards of Professional Nursing Practice: Authoritative statements of the actions and behaviors that all registered nurses, regardless of role, population, specialty, and setting, are expected to perform competently. (Chapter 1.1)

Statutory law: Written laws enacted by the federal or state legislature. For example, the Nurse Practice Act in each state is an example of statutory law that is enacted by the state government. (Chapter 5.2)

STEP tool: A situation monitoring tool used to know what is going on with you, your clients, your team, and your environment. STEP stands for Status of the clients, Team members, Environment, and Progress Toward Goal. (Chapter 7.6)

Student liability: When the student nurse is held responsible for their own actions that cause harm to clients or violate protocols. (Chapter 5.3)

Supervision: Appropriate monitoring of the delegated activity, evaluation of client outcomes, and follow-up with the delegatee at the completion of the activity. (Chapter 3.4)

Supervisory liability: When a clinical supervisor or preceptor is held

responsible for the actions of the student nurse or for failing to properly supervise them. (Chapter 5.3)

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. (Chapter 4.2)

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. (Chapter 4.2)

T

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 clients. (Chapter 8.5)

TeamSTEPPS® (Team Strategies and Tools to Enhance Performance and Patient Safety): An evidence-based framework to improve client safety through effective communication in health care environments consisting of four core competencies: communication, leadership, situation monitoring, and mutual support. (Chapter 7.6, Chapter 10.7)

Teamwork and collaboration: Functioning effectively within nursing and interprofessional teams, fostering open communication, mutual respect, and shared decision-making to achieve quality client care. (Chapter 10.7)

Temporary permit: A permit issued by the State Board of Nursing (SBON) that allows the applicant to practice practical nursing under the direct supervision of a registered nurse until their RN license is granted. (Chapter 11.3)

Time estimation: A prioritization strategy including the review of planned

tasks and allocation of time believed to be required to complete each task. (Chapter 2.5)

Time scarcity: A feeling of racing against a clock that is continually working against you. (Chapter 2.2)

Titrate: Making adjustments to medication dosage per an established protocol to obtain a desired therapeutic outcome. (Chapter 3.3)

Tort: An act of commission or omission that causes injury or harm to another person for which the courts impose liability. In the context of torts, "injury" describes the invasion of any legal right, whereas "harm" describes a loss or detriment the individual suffers. Torts are classified as intentional or unintentional. (Chapter 5.2)

Two-challenge rule: A strategy for advocating for client 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. (Chapter 7.6)

U

Unexpected conditions: Conditions that are not likely to occur in the normal progression of an illness, disease, or injury. (Chapter 2.3)

Unintentional tort: Acts of omission (not doing something a person has a responsibility to do) or inadvertently doing something causing unintended accidents leading to injury, property damage, or financial loss. Examples of unintentional torts impacting nurses include negligence and malpractice. (Chapter 5.2)

Unlicensed Assistive personnel (UAP): Any assistive personnel trained to function in a supportive role, regardless of title, to whom a nursing responsibility may be delegated. This includes, but is not limited to, certified nursing assistants or aides (CNAs), patient-care technicians (PCTs), certified

medical assistants (CMAs), certified medication aides, and home health aides. (Chapter 3.1)

Utilitarianism: A type of consequentialism that determines whether or not actions are right based on their consequences, with the standard being achieving the greatest good for the greatest number of people. (Chapter 6.2)

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 clients' needs. (Chapter 9.3)

V

Values: Individual beliefs that motivate people to act one way or another and serve as a guide for behavior. (Chapter 6.2)

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. (Chapter 4.2)

Veracity: An ethical principle meaning telling the truth. (Chapter 6.2)

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. (Chapter 4.2)

W

Whistleblower: A person who exposes any kind of information or activity that is deemed illegal, unethical, or not correct within an organization. (Chapter 10.5)