Leading Change in Health Systems:

Strategies for RN-BSN Students

Kathy Andresen

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Contents

About the Book ix

Introduction 1

Part I. Chapter 1 Navigating Leadership

1.1 Leadership Styles 7

1.2 Emotional Intelligence 21

1.3 Spotlight Application 24

Chapter 1 References & Attribution 25

Part II. Chapter 2 Leading Effective Solutions in Organizations

2.1 Organizational Structure 31

2.2 Organizational Vision, Mission, and Values 38

2.3 Spotlight Application 43

Chapter 2 References & Attribution 45

Part III. Chapter 3 Leading Effective Teams

3.1 Roles and Responsibilities of Health Care Professionals 51

3.2 Interprofessional Communication 56

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

Part IV. Chapter 4 Leading Evidence-Informed Decision Making

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

Part V. Chapter 5 Leading Effective Change

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

Part VI. Chapter 6 Leading Effective Outcomes

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

Part VII. Chapter 7 Leading Person-Centered Health Systems

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

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

About the Book

About the Book

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

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

Intended Audience

Students

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

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

Nurse Educators

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

Special Thanks & Acknowledgement

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

Attribution

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

Next- Introduction

Introduction

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

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

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

Next- Chapter 1 Navigating Leadership

PART I

CHAPTER 1 NAVIGATING LEADERSHIP

Learning Objectives

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

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

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

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

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

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

Applied Learning Activity 1.1 Work Styles Inventory

Take the short quiz below to determine your work style.

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can view it online here:
https://pressbooks.uwf.edu/nursingleadership/?p=347#h5p-19

Next: 1.1 Leadership Styles

1.1 Leadership Styles

Followership

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

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

Leadership and Management Characteristics

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

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

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

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

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

Competencies of ANA’s Leadership Standard of Professional Performance

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

Leadership Theories and Styles

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

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

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

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

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

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

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

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

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

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

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

Learn More

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

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

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

Table 1.1b Characteristics of Leadership Styles

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

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

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

Outcomes of Various Leadership Styles

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

Systems Theory

Systems theory is based on the concept that systems do not

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

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

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

The Just Culture model categorizes human behavior into three

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

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

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

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

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

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

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

Table 1.1c Classification of Errors Using the Just Culture Model

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

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

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

Applied Learning Experience 1.2 Leadership Self Assessment

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

Next: 1.2 Emotional Intelligence

1.2 Emotional Intelligence

Overview

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

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

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

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

Developing Emotional and Social Intelligence

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

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

Applied Learning Activity 1.2 Emotional Intelligence

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

Next: 1.3 Spotlight Application

1.3 Spotlight Application

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

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

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Next- Chapter 1 References & Attribution

Chapter 1 References & Attribution

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Chapter 2 Leading Effective Solutions in Organizations

PART II

CHAPTER 2 LEADING EFFECTIVE SOLUTIONS IN ORGANIZATIONS

Learning Objectives

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

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

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

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

Next: 2.1 Organizational Structure

2.1 Organizational Structure

Systems Theory and Health Care

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

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

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

Learning Exercise 2.1.1

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

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

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

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

Organizational Culture

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

Table 2.1.1 What is Organizational Culture? (Watkins, 2013)
"Culture is how organizations 'do things'." — Robbie Katanga **"In large part, culture is a product of compensation."** — Alec Haverstick **"Organizational culture defines a jointly shared description of an organization from within."** — Bruce Perron **"Organizational culture is the sum of values and rituals which serve as 'glue' to integrate the members of the organization."** — Richard Perrin

“Organizational culture is civilization in the workplace.” — Alan Adler

“Culture is the organization’s immune system.” — Michael Watkins

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

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

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

Further Research

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

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

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

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

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

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

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

Learning Exercise 2.1.2

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

Reflect on the following:

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

Next: Organizational Vision, Mission, and Values

2.2 Organizational Vision, Mission, and Values

Relationship Between Organizational Culture and Mission, Vision & Values

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

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

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

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

Vision, Mission, and Values & Leadership

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

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

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

Learning Exercise 2.2.1

Watch this video "How to Write a Mission Statement"

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

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

Learning Exercise 2.2.2

1.

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2.

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https://pressbooks.uwf.edu/nursingleadership/?p=306#h5p-28

3.

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

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

Next: 2.3 Spotlight Application

2.3 Spotlight Application

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

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

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https://pressbooks.uwf.edu/nursingleadership/?p=213#h5p-30

Chapter 2 References & Attribution

Chapter 2 References & Attribution

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Attribution

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Next- Chapter 3 Leading Effective Teams

PART III

CHAPTER 3 LEADING EFFECTIVE TEAMS

Learning Objectives

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

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

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

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

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

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

Table 3.1 IPEC Core Competencies

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

(Interprofessional Education Collaborative, n.d.)

Next: 3.1 Roles and Responsibilities of Health Care Professionals

3.1 Roles and Responsibilities of Health Care Professionals

IPEC Competency 1: Values/Ethics for Interprofessional Practice

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

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

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

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

IPEC Competency 2: Roles/ Responsibilities

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

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

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

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

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

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

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

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

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Next: 3.2 Interprofessional Communication

3.2 Interprofessional Communication

IPEC Competency 3: Interprofessional Communication

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

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

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

discussions and interactions that enhance team function.

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

programs and policies.

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

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

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

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

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

Table 3.2 Initiatives to Overcome Barriers to

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

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

Communication Strategies

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

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

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

Applied Learning Activity 3.2 Communication Style Inventory

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[Next: 3.3 Teams and Teamwork]()

[Appendix C]()

3.3 Teams and Teamwork

IPEC Competency 4: Teams and Teamwork

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

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

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

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

Developing effective teams is critical for providing health care

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

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

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

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

needed

STEP Tool

STEP is a tool for monitoring the delivery of health care

STEP Tool (AHRQ, 2020)

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

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

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

- Fatigue
- Workload
- Task Performance
- Skill
- Stress

Environment: Knowing Your Resources

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

Progression Towards Goal:

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

Cross Monitoring

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

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

I’M SAFE Checklist

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

I’m SAFE Checklist (AHRQ, 2020)

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

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

Example of Situation Monitoring

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

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

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

Mutual Support

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

Task Assistance

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

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

Example of Task Assistance

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

Feedback

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

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

requires correction or improvement.

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

Strategies for effective communication are found in Appendix C.

Next: 3.4 Spotlight Application

Supplemental Resources Appendix C

3.4 Spotlight Application

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

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

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Chapter 4 Leading

Evidence-Informed Decision Making

Supplemental Resources Appendix B Team Stepps Strategies

PART IV

CHAPTER 4 LEADING EVIDENCE-INFORMED DECISION MAKING

Learning Objectives

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

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

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

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

[Next: 4.1 Evidence-Informed Decision Making]

4.1 Evidence-Informed Decision Making

Evidence-Informed Leadership

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

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

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

Learning Experience 4.1.1

Watch the following YouTube video:

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

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

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

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

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

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

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

Perceptions of the Innovation

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

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

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

Learning Exercise 4.1.2

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

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

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

Composition of Staff

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

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

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

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

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

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

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

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

Contextual Information

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

Learning Exercise 4.1.3

Answer the following questions:

1. What kind of leaders would you like to work

with? Why?

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

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

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

Research Supports a Healthy Organization

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

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

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

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

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

Next: 4.2 Standards of Quality Care

4.2 Standards of Quality Care

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

American Nurses Association Definition of Quality

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

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

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

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

Learning Exercise 4.2.1

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

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

Framework of Quality Health Care

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

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

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

Reimbursement Models

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

CMS Quality Initiatives

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

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

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

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

Learn More

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

Accreditation

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

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

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

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

Core Measures

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

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

Learn More

Read more about the National Hospital Inpatient Quality Measures.

Patient Safety Goals

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

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

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

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

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

Learn More

Read the current agency-specific National Patient Safety Goals.

Next: 4.3 Spotlight Application

4.3 Spotlight Application

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

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

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Next Chapter 5 Leading Effective Change

PART V

CHAPTER 5 LEADING EFFECTIVE CHANGE

Learning Objectives

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

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

Nurse leaders must deal with the fears and concerns

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

Next: 5.1 Theoretical Approach to Change

5.1 Theoretical Approach to Change

Change Theories

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

Lewin's Change Model

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

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

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

policies and procedures (Kritsonis, 2005).

Example Using Lewin's Change Theory

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

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

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

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

Lippitt's Seven-Step Change Theory

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