

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

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

Example Using Lippitt's Seven-Step Change Theory

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

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

held accountable for performing accurate bedside handoff reporting.

Learn More

Read more about additional change theories in the [Current Theories of Change Management pdf](#).

Watch the video “[Lewin’s 3-Stage Model of Change: Unfreezing, Changing & Refreezing](#)” (8:06) by Education-Portal.com for more about Lewin’s change model.

Watch the video “[Rogers Diffusion of Innovation](#)” (3:15) by Kendal Pho, Yuri Dorovskikh, and Natalia Lara (Digital Pixels) for more about Rogers’ theory of innovation.

Change Management

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

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

Next: 5.2 Conflict Management

5.2 Conflict Management

The Theory of Conflict

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

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

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

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

Four Major Types of Conflict

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

Data Conflicts

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

Relationship Conflicts

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

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

Value Conflicts

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

Structural Conflicts

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

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

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

Dealing with Conflict—Different Approaches

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

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

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

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

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

Avoiding

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

Types of avoidance include:

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

What may result from avoidance:

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

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

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

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

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

Competing

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

Types of competition include:

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

What may result from competition:

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

Application to Nursing – Competing

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

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

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

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

Accommodating

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

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

Types of accommodation:

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

What may result from accommodation:

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

Application to Nursing – Accommodation

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

It may be appropriate to use an accommodating

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

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

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

Compromising

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

Types of compromising:

- Splitting the difference
- Exchanging concessions
- Finding middle ground

What may result from compromising:

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

Application to Nursing – Compromise

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

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

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

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

Collaborating

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

Types of collaboration:

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

What may result from collaboration:

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

Application to Nursing – Collaborating

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

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

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

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

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

What Does Each Approach Need?

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

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

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

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

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

Applied Learning Activity 5.2 Conflict Management Style



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

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

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



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Next: 5.3 Interprofessional Collaborative Practice

Supplemental Resources Appendix D Conflict Management Strategies

5.3 Interprofessional Collaborative Practice

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

Planning and Participating in Interdisciplinary Care Conferences

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

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

Learning Exercise 5.3.1

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

Reflections(Interprofessional Professionalism Collaborative, 2019):

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

Educating Clients and Staff

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

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

Acting As a Client Advocate

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

Making Client Referrals

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

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

Ensuring Continuity of Care

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

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

Preventing Medication Errors During Transitions

(World Health Organization, n.d.)

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

- Implementing formal structured processes

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

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

Reporting New Information and Changing Conditions

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

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

Contributing to the Evaluation of Client Outcomes

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

[Next: 5.4 Spotlight Application](#)

5.4 Spotlight Application

Scenario 1

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

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



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Scenario 2

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

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



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Scenario 3

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

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

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

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

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

“There isn’t!” Dr. Smith interrupts.

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

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

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



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Learn More

Visit the [TeamSTEPPS® Instructor Manual: Specialty Scenarios](#) for multiple AHRQ scenarios requiring application of TeamSTEPPS® to patient scenarios.

[Chapter 5 References & Attribution](#)

Chapter 5 References & Attribution

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[Next- Chapter 6 Leading Effective](#)

Outcomes

PART VI

CHAPTER 6 LEADING EFFECTIVE OUTCOMES

Learning Objectives

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

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

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

In this chapter, you will be exploring the quality improvement

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

[Next: 6.1 Quality Improvement Process](#)

6.1 Quality Improvement Process

Quality Improvement

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

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

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

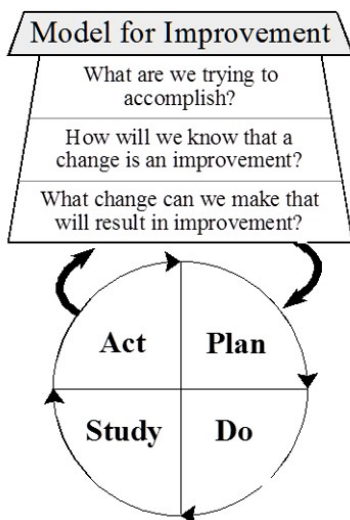


Figure 6.1 Quality Improvement Process (Cliffnorman, 2018)

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

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

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

It is important to note that quality improvement is different

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

Next: 6.2 Quality Improvement Measures

6.2 Quality Improvement Measures

Measuring Outcomes

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

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

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

Process Measures ([IHI, 2019](#))

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

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

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

Outcome Measures ([IHI, 2019](#))

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

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

percent unadjusted mortality

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

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

Examples of Existing Measures ([IHI, 2019](#))

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

Utilization Review

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

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

Using Informatics to Promote Quality

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

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

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

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

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

Quality Indicators

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

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

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

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

Learn More

Read about current quality measures promoting clinical excellence at the [Press Ganey website](#).

[Next: 6.3 Spotlight Application](#)

6.3 Spotlight Application

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

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

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



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Next Chapter 6 References & Attribution

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[7.1 Person-Centered Care](#)

PART VII

CHAPTER 7 LEADING PERSON-CENTERED HEALTH SYSTEMS

Learning Objectives

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

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

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

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

Learn More

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

[Next: 7.1 Person-Centered Care](#)

7.1 Person-Centered Care

Person-Centered Care

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

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



Figure 7.1 Person-Centered Care

Person-Centered Leadership

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

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

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

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

Learning Exercise 7.1.1

Questions to consider when leading person-centered decisions:

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

[Next: 7.2 Health Care Trends and Issues](#)

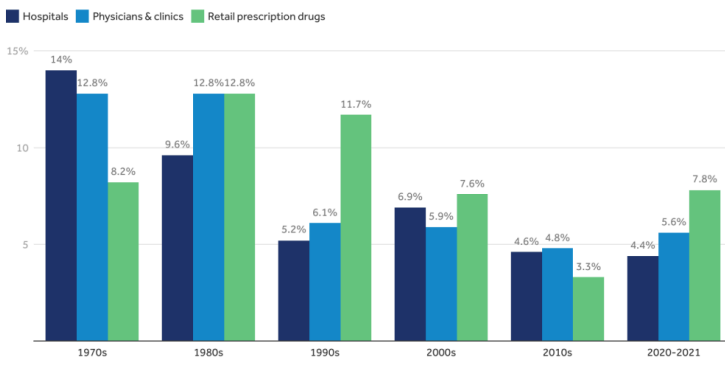
[Supplemental Resources Appendix E Person-Centered Strategies](#)

7.2 Health Care Trends and Issues

The Cost of Care

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

Average annual expenditures growth rate for select service types, 1970-2021



Source: KFF analysis of National Health Expenditure (NHE) data

Peterson-KFF
Health System Tracker

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

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

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

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

Aging Population

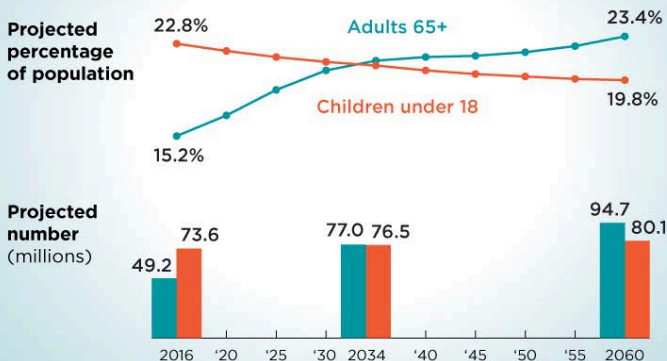
According to the Agency for Healthcare Research and Quality (AHRQ), the United States has a growing number of older adults (age 65 years or older) who are living longer than previous generations. It is anticipated that older adults will make up more than 20 percent of the U.S. population by 2030 (AHRQ,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



An Aging Nation

Projected Number of Children and Older Adults

For the First Time in U.S. History Older Adults Are Projected to Outnumber Children by 2034



Note: 2016 data are estimates not projections.

United States[®]
Census
Bureau

U.S. Department of Commerce
U.S. CENSUS BUREAU
census.gov

Source: National Population Projections, 2017
www.census.gov/programs-surveys/popproj.html

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

Increased Costs of Medical Technology

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

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

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

Increased Prescription Medication Costs

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

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

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

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

Affordable Care Act

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

Learn More

Read about the Affordable Care Act at [HHS.gov](https://www.hhs.gov).

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

Key Provisions of the ACA

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

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

The ACA also provides an avenue for consumers to appeal

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

Challenges to the ACA

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

What to Expect Next

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

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

Social Determinants of Health

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

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

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

Learn More

Read more about efforts addressing SDOH for improved economic stability and health care access in [Healthy People 2030](#).

[Next: 7.3 Spotlight Application](#)

7.3 Spotlight Application

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

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

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

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



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About the Contributors

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

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

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

scholarly interests and educational focus include organizational leadership, nursing education and health equity.

Charli Swanson

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

Glossary

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ISBARR: A mnemonic for the components of Introduction,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Patient safety goals: Guidelines specific to organizations

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Teamwork and collaboration: Functioning effectively within nursing and interprofessional teams, fostering open communication, mutual respect, and shared decision-making to achieve quality patient care.¹

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

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

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

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

Whistleblower: A person who exposes any kind of

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

Appendices

[Appendix A Scholarly Writing Resources](#)

[Appendix B Team Steps Strategies](#)

[Appendix C Communication Strategies](#)

[Appendix D Conflict Management Strategies](#)

[Appendix E Person-Centered Strategies](#)

[Appendix F Teaching Strategies](#)

Appendix A Scholarly Writing Resources

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

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

Appendix B Team Stepps Strategies

TeamSTEPPS®

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

Learn More

View this video about the TeamSTEPPS® framework²:

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



One or more interactive elements has been excluded from this version of the text. You can view them online here:

<https://pressbooks.uwf.edu/nursingleadership/?p=567#oembed-1>

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

Team Structure

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

Communication

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

members should use these skills to ensure accurate interprofessional communication:

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

Leadership

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

Effective team leaders demonstrate the following responsibilities³:

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

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

when needed.

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

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

Sharing the Plan

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

Brief Checklist

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

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

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

Monitoring and Modifying the Plan

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

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

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

Reviewing the Team’s Performance

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

Debrief Checklist⁷

The team should address the following questions during a debrief:

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

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

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

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

Situation Monitoring

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

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

STEP

The **STEP tool** is a situation monitoring tool used to know what is going on with you, your patients, your team, and your environment. **STEP** stands for **S**tatus of the patients, **T**eam members, **E**nvironment, and **P**rogress toward goal. See an illustration of STEP in Figure 7.7.⁹ The components of the STEP tool are described in the following box.¹⁰

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

Appendix C

Communication Strategies

Advocating for Safety with Assertive Statements

When a team member perceives a potential patient safety concern, they should assertively communicate with the decision-maker to protect patient safety. This strategy holds true for ALL team members, no matter their position within the hierarchy of the health care environment. The message should be communicated to the decision-maker in a firm and respectful manner using the following steps¹:

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

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

Examples of Using Assertive Statements to Promote Patient Safety

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

Two-Challenge Rule

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

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

CUS Assertive Statements

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

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

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

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

Assertive Statement Example

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

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

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

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

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

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

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

Learn More

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

ISBARR

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

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

4. AHRQ Patient Safety. (2017, July 26). *Introduction to the fundamentals of TeamSTEPPS® concepts and tools*. [Video].

YouTube. Video in the Public Domain. <https://youtu.be/fxIRtpzsUug>

5. Institute for Healthcare Improvement (n.d.). *ISBAR trip tick*.

<http://www.ihl.org/resources/Pages/Tools/ISBARTripTick.aspx>

6. Grbach, W., Vincent, L., & Struth, D. (2008). *Curriculum developer for simulation education*. QSEN Institute.

<https://qsen.org/reformulating-sbar-to-i-sbar-r/>

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

Nursing Considerations

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

Communication Guidelines for Nurses⁷

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

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

nursing progress notes?

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

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

Sample ISBARR Report From a Nurse to a Health Care Provider

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

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

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

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

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

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

Handoff Reports

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

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

The Joint Commission encourages the standardization of critical content to be communicated by interprofessional team members during a handoff report both verbally (preferably face to face) and in written form. Critical content to communicate to the receiver in a handoff report includes the following components¹⁰:

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

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

Learn More

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

[View a video example of bedside handoff reporting.](#)

Closed-Loop Communication

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

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

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

Closed-Loop Communication Example

Doctor: “Administer 25 mg Benadryl IV push STAT.”

Nurse: “Give 25 mg Benadryl IV push STAT?”

Doctor: “That’s correct.”

Nurse: “Benadryl 25 mg IV push given at 1125.”

I-PASS

I-PASS is a mnemonic used to provide structured communication among interprofessional team members. I-PASS stands for the following components¹¹:

I: Illness severity

P: Patient summary

A: Action list

S: Situation awareness and contingency plans

S: Synthesis by receiver (i.e., closed-loop communication)

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

Table C.1 Sample I-PASS Verbal Handoff¹³

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

Transforming pediatric GME. *Pediatrics*, 129(2), 201-204.

<https://www.ipassinstitute.com/hubfs/I-PASS-mnemonic.pdf>

Table C.1 Sample I-PASS Verbal Handoff

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

Documentation

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

Learn More

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

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

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

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

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

Appendix D Conflict Management Strategies

Managing Conflict

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

When conflict occurs, the **DESC tool** can be used to help resolve conflict by using “I statements.” DESC is a mnemonic that stands for the following¹:

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

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

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

Example of Using the DESC Tool²

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

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

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

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

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

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

Appendix E

Person-Centered Strategies

Interprofessional Person-Centered Competencies

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

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

Components of IPEC's Values/Ethics for Interprofessional Practice Competency³

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

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

team-based care.

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

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

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

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

Learn More

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

Read more about cultural diversity, cultural humility, and integrating culturally responsive care in the [“Diverse Patients”](#) chapter of *Open RN Nursing Fundamentals*.

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

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

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

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

View the [“How does interprofessional](#)

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

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

Reflective Questions

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

Appendix F Teaching Strategies

Teaching Strategies

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

Applied Learning Activities

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

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

Spotlight Applications

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

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

Institute for Healthcare Improvement (IHI)

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

[Chapter 1 Navigating Leadership](#)

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

1. <https://www.ihl.org/>

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

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

[Chapter 2 Leading Effective Solutions in Organizations](#)

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

[Chapter 3 Leading Effective Teams](#)

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

[Chapter 5 Leading Effective Change](#)

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

contribute to a Quality Improvement proposal in their workplace..

[Chapter 6 Leading Effective Outcomes](#)

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

Writing Support

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