In any discipline, most practitioners think of a leader as someone with positional authority. Terms such as manager, director, chief, and leader convey positional authority. In healthcare organizations, a hierarchy exists of “who is in charge.” Realistically, however, every registered nurse is seen by law as a leader—one who has the opportunity and authority to make changes for his or her patients. Even as far back as Florence Nightingale’s era, patient safety was important. She focused on changing the way health care was delivered to make a difference in the outcomes of care for those who served in the Crimean War. Yet, in the United States, it was not until the end of the twentieth century that major efforts refocused on the basic safety and quality outcomes of care for patients. This shift to being consumed with a passion for patient safety is a hallmark of today’s healthcare delivery and the target for the care of tomorrow. This chapter provides an overview of the key thoughts about patient safety as the basis for all aspects of leading and managing in nursing. Patient safety, and subsequently quality of care, is why the public entrusts us with licensure and why we use our passion for caring.

**OBJECTIVES**

- Identify the key organizations leading patient safety movements in the United States.
- Value the need for a focus on patient safety.
- Apply the concepts of today’s expectations for how patient safety is implemented.

**TERMS TO KNOW**

- Agency for Healthcare Research and Quality (AHRQ)
- Institute for Healthcare Improvement (IHI)
- Magnet Recognition Program®
- DNV (Det Norske Veritas)
- Institute of Medicine (IOM)
- National Quality Forum (NQF)
- The Joint Commission
INTRODUCTION

In Chapter 1, the concepts of leading and managing were presented. The question is, however, leading for what? No issue is more prominent in the literature or in healthcare organizations than the concern for patient safety. Although many other aspects of health care are discussed, they all center on patient safety. Many factors and individuals have influenced the nursing profession’s and the public’s concern about patient safety, but the seminal work was *To Err is Human: Building a Safer Health System* (2000), produced by the Institute of Medicine (IOM). From that report through the 2005 publication, *Preventing Medication Errors*, the IOM focused its work on multiple issues surrounding patient safety. Even more popularized publications, such as *How Doctors Think* (Groopman, 2007) and *The Best Practice: How the New Quality Movement is Transforming Medicine* (Kenney, 2008), show how important the basic building block of quality—patient safety—is. This focus fits well with the basic patient advocacy role that nurses have supported over decades.

Because the core of concern in any healthcare organization is safety, it also is the core for leaders and managers in nursing. Safety, and subsequently quality, should drive such aspects of leading and managing as staffing and budgeting decisions, personnel policies and change, and information technology and delegation decisions. Most professionals would agree that three major driving forces are behind the current emphasis on quality: IOM, the Agency for Healthcare Research and Quality (AHRQ), and The National Quality Forum (NQF). Also, other groups such as The Joint Commission, the new accrediting organization (the Det Norske Veritas [DNV]), and the Magnet Recognition Program® have incorporated specific standards and expectations about safety and quality into their respective work. No nurse can function today without a focus on patient safety, nor can any nurse leader or manager.

THE INSTITUTE OF MEDICINE REPORTS ON QUALITY

Although many reports about quality and safety had been issued before 2000, *To Err is Human* is the report credited with causing sufficient alarm about how widespread the issue of patient safety concerns was. When the number of deaths (98,000 annually) attributable to medical error was announced, the interest in safety intensified. Suddenly this issue was not related to just a few isolated instances nor was it likely to diminish without some concerted action. Probably the hallmark of this publication was the acknowledgment that errors commonly occurred because of system errors rather than individual practitioner incompetence. This insight, that it was the system and not the practitioners that needed to be addressed,
placed even more emphasis on roles such as chief medical officers and chief nursing officers. Hospital boards that once focused almost exclusively on finances suddenly wanted more of their agendas devoted to discussions about quality and patient safety. The call for a comprehensive approach to the issue of improving patient safety really spurred the release of a second IOM report. This next report, *Crossing the Quality Chasm*, was released the subsequent year (IOM, 2001). The intent of this second book was to improve the systems within which health care was delivered; after all, the first report identified that systems rather than incompetent people were the major concern. The report spelled out six major aims in providing health care, as shown in Box 2-1.

These aims were designed to enhance the quality of care that was delivered. Most are well documented in the literature, and two of them seem to be receiving much attention. One, patient-centered care, has lessened the past practices of disciplines (e.g., nursing and pharmacy) and services (e.g., orthopedics and urology) vying for control of the patient. Now, because care is to be rendered with the patient rather than to the patient, the emphasis of care is about what is provided—not who controls the decision about care. The second aim, equitable, has emphasized what the literature refers to as disparities and has led to thoughtful consideration of what best practices are and how they can be provided to the masses.

The report went on to acknowledge elements of care that nurses commonly value. For example, the report cited the idea of a healing environment, individualized care, autonomy of the patient in making decisions, evidence-based decision making, and the need for transparency. Although those elements of a healthcare delivery system might not seem so dramatic today, they were fairly revolutionary in 2001. This report also provided substantive support for the use of information technology within health care. In addition, it provided the impetus for payment methods being based on quality outcomes and addressed the issue of preparing the future workforce. This latter recommendation formed the basis for another IOM report, *Health Professions Education: A Bridge to Quality* (IOM, 2003).

Unlike the earlier reports, the *Health Professions Education* report emerged as the work of an invitational summit. In this report, one of the major concerns about safety was exposed publicly, namely that we educate disciplines in silos and then expect them to function as an integrated whole. This is true of both basic and continuing professional education. The
report stated, “All health professionals should be educated to deliver patient-centered care as members of an interdisciplinary team, emphasizing evidence-based practice, quality improvement approaches, and informatics” (IOM, 2003, p. 3). Box 2-2 emphasizes those five competencies about health professional education.

The idea of this report was to shrink the chasm between learning and reality so that learning was enhanced and reality was more closely aligned with that learning. A commitment to this redirection of learning is critical for “learning organizations,” a term coined by Peter Senge. Thus constant learning is a commitment every healthcare professional must have. Although it is the individual’s accountability to maintain competence and participate in learning, the organization can hinder or enhance that individual’s need to meet this expectation. Learning organizations exhibit a positive commitment to enhance people’s learning and changing.

After looking at safety, the system and core competencies of health professionals, the IOM turned its attention to the workplace itself. As a result, many nurses think of the IOM report Keeping Patients Safe: Transforming the Work Environment of Nurses (IOM, 2004) as the major impetus behind many changes that improved the working conditions for nurses. Because nurses are so inextricably linked with patients, it was logical that the importance of the role of nurses in health care emerged as an area of focus. This report identified that nurses had lost trust in the organizations in which they worked and that “flattening” the organization resulted in fewer clinical leaders being available to advocate for staff and patients and to provide resources to those delivering direct care. Further, numerous sources of unsafe equipment, supplies, and practices were discussed. Finally, so many organizations were still engaged in punitive practices related to errors rather than redirecting attention to the broader view of the system.

This report focused on direct-care nurses being able to participate in decisions that affected them and their provision of care, which helped reinforce the ongoing work of shared governance. Addressing staffing issues was accomplished on a broad scale. In other words, the broad processes for determining staffing requirements and how to address those were identified. Average hours per patient day of care, staffing levels, turnover rates, public reporting about those data, support for annual and planned education, and specifics, such as handwashing and medication administration, were addressed. Also, this report identified the importance of governing boards understanding the issues of safety and propelled the idea of the chief nursing officer participating in board meetings in organizations that had not already embraced this practice. Redesigning both the work of nurses and the workspace was acknowledged as critical to maximizing a positive workforce.

Two other related reports in what is called the Chasm Series also provide guidance to nursing. These reports—Improving the Quality of Health Care for Mental and Substance-Use Conditions (IOM, 2005) and Preventing Medication Errors (IOM, 2006)—address two common encounters in healthcare organizations. Many patients who arrive at a hospital for medical or surgical intervention come with an underlying mental health or substance-use condition that complicates the basic intervention strategy. Also, medication errors are the source of many issues about patient safety. Almost all hospitalized patients and most people who have a healthcare condition and are not hospitalized use medications. The prevalence of the numbers of medications that pass hands in any organization alone would justify the work of this report.

Each of these reports fits within the IOM’s focus on quality and an attempt to make health care a quality endeavor. Together, these reports and others to be developed provide direction for the delivery of care and contain implications, if not outright recommendations, for nursing. These reports form the core of the work around quality in most organizations today. Further, they support many issues nurses have identified as key to quality care.
CHAPTER 2 Patient Safety

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

The Agency for Healthcare Research and Quality (AHRQ) is the primary Federal agency devoted to improving quality, safety, efficiency, and effectiveness of health care (Agency for Healthcare Research and Quality [AHRQ], 2008). As seen in numerous IOM reports, recommendations about what AHRQ could do to enhance safety were prominent. AHRQ’s website (www.ahrq.gov) is an information-rich source for providers and consumers alike. For example, several healthcare conditions are identified in the outcomes research section. Because AHRQ maintains current information, it is a readily available source, even if the number of conditions is limited. Another example of AHRQ’s work is the fairly well-known “Five Steps to Safer Health Care,” which is available at www.ahrq.gov/consumer/5step.htm. Nurses who work in clinics will find these steps especially helpful in working with patients. This list identifies ways in which nurses can support people in assuming a more influential role in their own care. Box 2-3 lists the five steps.

If a patient does not volunteer the above information, a nurse could readily seek clarification by asking questions related to each of those items. This is an example of reinforcing work that has been judged to benefit patients.

AHRQ is also the source for the stay healthy checklists for men and women. These checklists can be useful in any clinical setting in helping people assume a greater understanding of their own care.

BOX 2-3 FIVE STEPS TO SAFER HEALTH CARE

1. Ask questions if you have doubts or concerns.
2. Keep and bring a list of ALL medications you take.
3. Get the results of any test or procedure.
4. Talk to your doctor about which hospital is best for your health needs.
5. Make sure you understand what will happen if you need surgery.


EXERCISE 2-1

Go to www.ahrq.gov/consumer and review what sources of information are available to people for whom you may provide care. Scroll to “prevention and wellness” and click on “Men Stay Healthy at 50+.” Review the information there, and then use the back button to return to the prior page and click on “Women Stay Healthy at 50+.” What are the differences in the checklists based on gender?

THE NATIONAL QUALITY FORUM

The National Quality Forum (NQF) is a membership-based organization designed to develop and implement a national strategy for healthcare quality measurement and reporting. As a result, the Centers for Medicare & Medicaid Services (CMS) formed its no-pay policy based on the growing work of NQF of “never events.” In other words, CMS will no longer pay for certain conditions that result from what might be termed poor practice or events that should never have occurred while a patient was under the care of a healthcare professional. The NQF brings together providers, insurers, patient groups, federal and state governments, and professional associations and purchasers, to name a few of the groups comprising the membership. This diversity provides a venue for open discussion about healthcare quality that does not normally happen. Having the patients’ perspectives at the same time as the perspectives of the insurers and providers allows for a broad view of any issue. The Healthcare Facilities Accreditation Program, a CMS-deemed authority, has adopted the NQF’s 34 Safe Practices.

NQF refers to nurses as “the principal caregivers in any healthcare system” (National Quality Forum [NQF], 2008). This acknowledgment, while welcomed, is also a challenge for nurses to perform in the best manner possible to lead organizations in their quests for quality.

Through its consensus process, NQF created a list of endorsed nurse-sensitive care standards. These standards are divided among three key areas: patient-centered outcome measures, nursing-centered intervention measures, and system-centered measures. The first group includes fall and pressure ulcer prevalence; the second, smoking cessation programs with three diagnosis groups; and the third, skill mix, turn-
over rates, nursing care hours per patient day, and a practice environment scale. Box 2-4 lists the nurse-sensitive care standards from 2008. These standards create a common definition of measures so that any group can collect and report data in a manner comparable to other groups. As a result, those measures form the basis for comparison of quality.

**EXERCISE 2-2**
Go to [www.qualityforum.org/pdf/nursing-quality/finalnursesed-preparation.pdf](http://www.qualityforum.org/pdf/nursing-quality/finalnursesed-preparation.pdf) to read the evidence related to education. Assume that you work in a facility that does not provide support (time off, tuition reimbursement, recognition of educational achievement). How could you use this information to change workplace policies and practices?

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**THE JOINT COMMISSION**

The Joint Commission, formerly known as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), is a not-for-profit organization that accredits healthcare organizations. It has “deemed” status from the CMS, which means that an organization that meets The Joint Commission standards is deemed to have met the standard that CMS sets.

The Joint Commission basically reinvented itself in the early twenty-first century. It turned its focus to outcomes and created the approach of unannounced visits. Before this approach, a heavy emphasis was on processes, and when organizations were told about the date of their scheduled visit from The Joint Commission, numerous staff members were assigned to bring medical records up to date, repair equipment, and update policies and procedures. Now, however, the organization must be ready on an ongoing basis to address the review that the team of assessors conducts. The intent of this change in practice is to enhance organizations constantly meeting standards rather than complying sporadically. The change in focus from processes to outcomes further emphasizes that intent is not sufficient. As part of this redirection of this important organization, an emphasis on patient safety emerged to a prominent place. As a result, The Joint Commission issues, with input, annual patient safety goals and a list of “do-not-use” terms, symbols, and abbreviations and posts sentinel events. All of these efforts are directed toward improving patient safety. In addition, with the NQF, The Joint Commission sponsors the Eisenberg Award for patient safety.

**BOX 2-4 NURSE-SENSITIVE CARE STANDARDS**

**Patient-Centered Outcome Measures**
- Death among surgical inpatients with treatable serious complications (failure to rescue)
- Pressure ulcer prevalence
- Patient falls
- Falls with injury
- Restraint prevalence (vest and limb)
- Urinary catheter–associated infections (CAUTI) rate for intensive care unit (ICU) patients
- Central line catheter–associated bloodstream (CLABSI) infection rate for intensive care unit (ICU) and neonatal intensive care unit (NICU) patients
- Ventilator-associated pneumonia (VAP) rate for intensive care unit (ICU) and neonatal intensive care (NICU) patients

**Nursing-Centered Intervention Measures**
- Smoking cessation counseling for acute myocardial infarction (AMI)
- Smoking cessation counseling for heart failure (HF)
- Smoking cessation counseling for pneumonia (PN)

**System-Centered Measures**
- Skill mix
- Nursing care hours per patient day
- Practice environment scale-nursing work index (PES-NWI)
- Voluntary Turnover

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**THE DET NORSKE VERITAS/NATIONAL INTEGRATED ACCREDITATION FOR HEALTHCARE ORGANIZATIONS℠**

Over the past several years, an internationally based organization that provides accreditation in a variety of fields has entered healthcare accreditation. The Det Norske Veritas (DNV) or National Integrated Accreditation for Healthcare Organizations℠ (NIAHO℠) (2009) is a direct competitor of The Joint Commission, and both organizations are concerned with quality of care. The DNV (Det Norske Veritas, formerly known as TUV Healthcare Specialists and now known as National Integrated Accreditation for Healthcare Organizations) is based on a set of international standards known as International Organization for Standardization (ISO).
CHAPTER 2  Patient Safety

The main difference between The Joint Commission and the DNV is that the latter surveys accredited organizations annually so that an organization has considerably more information to work with (Lee, 2009). Because the DNV has worked closely in other fields in which safety and quality are concerns, the DNV has employed in health care the same approaches it used elsewhere. Although the organization is committed to safety and quality, it is too early to identify the impact this organization will have on safety and quality issues because it was just recognized as a deemed organization in 2008.

MAGNET RECOGNITION PROGRAM®

The Magnet Recognition Program® is the only national designation built on and evolving through research. This program is designed to acknowledge nursing excellence. Through the 14 Forces of Magnetism (www.nursecredentialing.org/Magnet/ProgramOverview/ForcesofMagnetism.aspx), organizations must demonstrate how they provide excellence. Although each of the forces contributes to patient safety, two are specifically focused on quality: quality of care and quality improvement. In the model created in 2008, the core of the model is empirical outcomes. Magnet™, like other organizations mentioned here, focuses on quality care (www.nursecredentialing.org/Magnet/NewMagnetModel.aspx).

INSTITUTE FOR HEALTHCARE IMPROVEMENT

The Institute for Healthcare Improvement (IHI) is dedicated to rapidly improving care through a variety of mechanisms including rapid cycle change projects. (See the Theory Box below.) IHI is an independent, not-for-profit organization. Working with the Robert Wood Johnson Foundation (RWJF), IHI created an innovative project called Transforming Care at the Bedside (TCAB). Although TCAB currently is applied only to medical-surgical inpatient units, it addresses safety and reliability, care team vitality, patient-centeredness, and increased value. Spreading innovative approaches to patient safety issues is critical to achieve major patient safety goals.

BOX 2-5  THE STAR APPROACH TO PATIENT SAFETY

S—stop to concentrate on the task
T—think about the task
A—act to accomplish the task
R—review how well the task was accomplished


MEANING FOR LEADING AND MANAGING IN NURSING

Many of the approaches to patient safety and, before that, aviation and nuclear energy safety, consist of strategies to alert us to safety issues. For example, Kenney (2008) related a story about a practice at Sentara in Norfolk, Virginia. The practice was called STAR, which represented four key elements as seen in Box 2-5. Those four elements make perfect sense in delivering patient care; they make equal sense in performing managerial or leadership tasks.

THEORY BOX

<table>
<thead>
<tr>
<th>THEORY/CONTRIBUTOR</th>
<th>KEY IDEA</th>
<th>APPLICATION TO PRACTICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rogers (2003)</td>
<td>• A process of communication about innovation to share information over time and among a group of people. • Allows for non-linear change. • More complex change is less likely to be adopted. • Early adopters serve as role models</td>
<td>• Engage key leaders in a change to infuse the energy from early adopters. • Using Twitter in the hospital culture to engage employees communicates changes quickly.</td>
</tr>
</tbody>
</table>
This concern for patient safety is not limited solely to hospitals or to the United States, as Wagner, Capezuti, and Rice (2009) point out. In a study comparing long-term care settings in the United States, Canada, and other countries, one of the major findings was the discrepancy between the nurse managers’ view of a safety culture and the staff nurses’ view. The managers saw the culture as more positive than did the staff. This finding suggests that looking at the culture of safety from multiple views would be important.

Although the errors that nurse leaders and managers make do not typically result in a patient’s morbidity or mortality, if each decision that is not related to patient care were treated with this type of focus, we would likely make solid decisions more frequently. Often managerial and leadership tasks, like many others we perform, are squeezed into a hectic day. By stopping to concentrate on the work before us, we increase our chances of understanding the complexity of the situation and the ramifications of various decisions. By thinking through various scenarios, we are likely to eliminate strategies and methods that would not meet our needs and be more likely to narrow our choices of best actions to take. Then, if after an action, we took time to review how well some decision was enacted, we would increase our knowledge about particular types of problems and enhance our skill at making decisions.

Similarly, it is possible to look at the five core competencies defined in the 2003 IOM report and create a professional evaluation system and continuing education program. In essence, these five core competencies could drive the personnel performance within an organization. Using some form of a chart, continuing educators could redesign organizational-sponsored learning activities by illustrating how the proposed learning activities contribute to developing, maintaining, or enhancing the five core competencies. This unified focus would help both the individual and the organization. Further, having geographically accessible or virtual demonstration sites would allow physicians, nurses, and others the opportunity to demonstrate through simulation how the five core competencies relate to specific practice areas. These major overhauls of organizational systems require commitment from the organization’s largest department—nursing.

One of the challenges for nurses in any position, and especially for leaders and managers, is the task of keeping current with the literature. For example, Shaffer and Tuttas (2009) identify how nurse leaders need to be responsible for safety, as well as quality and patient satisfaction. Computer technology has allowed us to gather data, analyze it, share it with other colleagues, and read about studies through online availability. Based on the original IOM observation that the numbers of journals, and thus articles, had multiplied dramatically over the past decades, knowing what to read and where to search is critical. Hoss and Hanson (2008) provided a way to consider evidence available through websites. (See the Literature Perspective below.)

### Literature Perspective


The amount of evidence-based practice-related content has grown dramatically. Thus evaluating websites for bias, validity, and patient population descriptors has become increasingly important.

Several national sources provide quality improvement data. Examples of these are the Agency for Healthcare Research and Quality, the Institute for Healthcare Improvement, and The Joint Commission.

The authors proposed three questions to evaluate websites:

1. Is the information from a recognized authority? (2) Does the website comply with voluntary standards? (3) Who is the intended audience? Examples of recognized authorities are most peer-reviewed journals, the Cochrane Database of Systematic Reviews, and The Virginia Henderson International Nursing Library. An example of the second is the standards of Medline Plus, which requires meeting several criteria to have a link from its site. An example of the third is to consider what the url extension is. For example, .com refers to commercial enterprises; .edu to educational institutions; .org to organizations (frequently professional and nonprofit societies); and .gov to city, county, state, or federal government.

Questions of validity relate to the following: Is the author biased? Is the information complete and accurate? Are the recommendations valid? Will the information help the patient?

**Implications for Practice**

Knowing what sources provide quality information helps nurses use their time effectively.
CHAPTER 2  Patient Safety

The challenge for competent practice today is to stay well-informed about the best evidence or best practices that exist in any practice situation, including that of management and leadership. As the healthcare professions have focused on creating evidence about various practices, the amount of information has become overwhelming. The Research Perspective above illustrates one study focused on one aspect of the IOM competencies—patient-centeredness. Although no significant differences were found in this study, it refutes the pilot work on which it is based. More research in this important aspect of care is needed.

CONCLUSION

Creating a culture of safety is everybody’s business; and nurses, who are so integral to care, are key players in this important work. Every nurse has the accountability to challenge any act that appears unsafe and to stop actions that do not concur with the patient’s best interest. Being proactive is insufficient in itself; examining practices and conditions that support errors is critical, as is sharing knowledge that can redirect care. In this challenging context, nurses continue to provide care and provide the organizational “glue” that supports patient care being accomplished in a safe, effective, and efficient manner.

THE SOLUTION

A multidisciplinary group was formed to address the problem. Our facility did not have some of the necessary equipment such as lift equipment, adult-size positioning devices, and beds large enough to accommodate larger patients. We purchased the necessary equipment, and we also implemented a safe patient-handling program. The facility “skin champions” also developed an incontinence protocol and a friction/shear protocol.

Participation by our hospital in a multisite research study on pressure ulcer development in critically ill children has shown that our pressure ulcer incidence is significantly lower than that of other participating children’s hospitals.

Success of the pediatric pressure ulcer prevention program is the result of extensive multidisciplinary collaboration—support from hospital administration, physicians, and frontline nurses. Utilization of evidence-based practice and research has also driven successful changes in our program. The desire to continually improve pressure ulcer prevention strategies has become the culture within our hospital.

—Vickie S. Simpson

RESEARCH PERSPECTIVE


Based on the IOM’s emphasis on patient-centered care (PCC), this group of researchers created a randomized study using a post-test design. This study was based on a pilot study that showed better results when care was designed as patient-centered. All subjects (n=116) were preoperative patients at a bariatric center of excellence. Two tools were used to assess their needs before discharge and then within 24 to 48 hours after discharge. The researchers also tracked falls, infections, and length of stay—three factors associated with quality care. Intervention nurses learned about patient-centered care before the initiation of the study. Patients were all admitted to the same unit for care but were divided geographically by control group and intervention group. The intervention group patients were called in advance of hospitalization to determine goals, concerns, expectations, and fears so that a more personalized approach to care could be provided. Although there was no statistical significance between the two groups, the PCC group patients “were found to be more open to communicating feelings, more talkative, and comfortable expressing negative experiences” (¶2, Qualitative Results). What does this mean?

Implications for Practice

To achieve IOM goals, research needs to explore how the goals may be used in practice. Patient-centered care is an advocated concept and is now present in many patient care situations. Although this study was conducted in a bariatric center, the concepts of assessing needs, transitioning home, and experiencing positive care in the hospital can be applied across many settings. Because no statistical significance was achieved, nurses who use this study elsewhere should consider why this outcome may have occurred.
THE EVIDENCE

The Nurse-Sensitive Care Standards, developed by the National Quality Forum (2008), are conditions associated with the quality of nursing care. These form the evidence associated with the care nurses provide.

- Death among surgical inpatients with treatable serious complications (failure to rescue)
- Pressure ulcer prevalence
- Patient falls
- Falls with injury
- Restraint prevalence (vest and limb)
- Urinary catheter–associated infections (CAUTI) rate for intensive care unit (ICU) patients
- Central line catheter–associated bloodstream (CLABSI) infection rate for intensive care unit (ICU) and neonatal intensive care unit (NICU) patients
- Ventilator-associated pneumonia (VAP) rate for intensive care unit (ICU) and neonatal intensive care (NICU) patients
- Smoking cessation counseling for acute myocardial infarction (AMI)
- Smoking cessation counseling for heart failure (HF)
- Smoking cessation counseling for pneumonia (PN)
- Skill mix
- Nursing care hours per patient day
- Practice environment scale-nursing work index (PES-NWI)
- Voluntary turnover

NEED TO KNOW NOW

- Know how to retrieve literature related to best practice and evidence in your area of practice.
- Practice precautionary strategies such as the STAR approach.
- Select workplaces based on the support for the core competencies as defined by IOM.
- Practice what to say to stop an unsafe practice.

CHAPTER CHECKLIST

This chapter focused on the core of leading and managing in nursing, namely an intense passion for patients and their safety. To lead and manage effectively, a nurse must be passionate about quality and patient safety. The nurse leader and manager, as well as followers, must be able to identify potential safety issues, intervene quickly when a safety issue exists, and think skillfully after a safety violation so that all may learn.

- The key organizations dealing with the patient safety movement are the following:
  - The Institute of Medicine
  - The Agency for Healthcare Research and Quality
  - The National Quality Forum
  - The Joint Commission
  - The DNV/NIAHOSM
  - The Magnet Recognition Program®
  - The Institute for Healthcare Improvement
  - Considerable potential to capitalize on the information in the IOM reports and in evidence-based research and best practices exists.
  - Keeping current with the literature is a challenge we must meet.
  - Creating a culture of safety is everyone’s job.

TIPS FOR PATIENT SAFETY

- Use the STAR approach: Stop, Think, Act, Review.
- Use the IOM competencies to frame your actions.
- Keep current with the evidence and best practices.
- Use only quality sources, especially websites.
- Read general nursing literature regarding other organizations’ work related to safety.
REFERENCES


SUGGESTED READINGS

Agency for Healthcare Research and Quality: https://subscriptions.ahrq.gov/service/multi_subscribe.html?code=USAHRQ.
Institute for Healthcare Improvement: www.ihi.org/ihi.