Leadership and Management for Every Nurse, 2nd Edition

Author: Lynn C. Parsons, DSN, RN, NE-BC

Course Objectives:

- Discuss the difference between leadership and management, the benefits of both concepts to effective nursing practice, and their roles in nursing.
- Describe delegation principles utilized in nursing practice.
- Prioritize care and use the principles of triage in emergent patient scenarios.
- Describe problem-solving processes and quantitative tools used to make decisions.
- Describe resources needed for management of a nursing care unit.
- Discuss the importance of strategic planning for healthcare organizations.
- Describe the different organizational structures used in healthcare organizations.
- Outline strategies to build cohesive teams for healthcare organizations.
- Discuss the concepts of patient-centered care within the contexts of nursing and nursing management.
- Describe strategies for managing conflict and stress.
- Describe the impact of power and influence on nursing practice.
- Apply legal principles to nursing practice.
- Discuss ethical dilemmas and the available resources for managing them.
- Describe the various roles of the nurse and the ways in which these roles facilitate change.
- Explain how professional organizations provide leadership opportunities.

ABOUT THE AUTHOR

Lynn C. Parsons, DSN, RN, NEA-BC, is a Professor of Nursing and Chairperson, Department of Nursing, at Morehead State University in Morehead, Kentucky. Dr. Parsons has 32 years of experience as a registered nurse, with a strong background in hospital administration as a nurse manager and nursing supervisor and in academic administration, serving in the roles of director/chairperson and associate dean of a large science college. Her clinical experience is primarily in orthopedic trauma and surgical nursing and neuroscience. Dr. Parsons has numerous juried platform presentations and refereed publications, which include research-based publications in nurse delegation decision-making. She is board certified as a Nurse Executive Advanced through the American Nurses Credentialing Center (ANCC). Her initial certification as a Nurse Administrator was awarded by the ANCC through examination in 1984. Her Master of Science in Nursing was conferred in 1987 by Northern Michigan University in Marquette, with a program of study exclusively focused on nursing service administration. She received her Doctor of Science in Nursing, with a program of study focused on nursing administration and healthcare policy, in 1995 from the University of Alabama at Birmingham.

ABOUT THE CONTRIBUTING AUTHORS

Debra Sullivan, PhD, MSN, RN, CNE, COI, is currently an assistant professor at Middle Tennessee State University (MTSU) where she teaches undergraduate and graduate nursing students. At the school of nursing she has been part of the leadership team and has held several coordinator roles. She has been trained in Quality and Safety Education for Nursing (QSEN) – a national initiative within nursing with the purpose to decrease medical errors. Dr. Sullivan has been a leader in nursing, serving as President of the Tennessee Nurse Association District 15 and serving on the board of directors for Sigma Theta Tau International, Xi Alpha. She has published several nursing articles and has made podium presentations and posters locally, nationally, and internationally. Before moving to Middle Tennessee, she held leadership positions within a large hospital system in Houston, TX, including Director of Clinical Education at a suburban hospital and at the corporate offices. She earned a PhD from University of Nevada, Las Vegas; an MSN from University of Texas at Tyler; a BSN from University of Texas, Medical Branch; and an ADN from Houston Baptist University.

Deborah Weatherspoon, RN, CRNA, MSN, PhD, is a professor of nursing at Walden University in the graduate school in the Leadership and Management track. She began her RN career in 1978 with a degree from Memphis State University. She then continued her education at Middle Tennessee State University’s School of Anesthesia to become a CRNA. Ms. Weatherspoon then worked in clinical anesthesia, until returning to school and earning a Masters in Nurse Education in 2009 from Middle Tennessee State University. As a CRNA, she managed four hospital anesthesia departments and lead a CRNA group. Dr. Deborah Weatherspoon received her PhD from the University of Tennessee at Knoxville with a focus on education.
ABOUT THE CONTENT EDITOR
Anne P. Manton PhD, RN, PMHNP-BC, FAEN, FAAN, is a Fellow in both the American Academy of Nursing and the Academy of Emergency Nursing. She has served in a number of management and leadership roles, including as director of emergency nursing services, acting dean of Fairfield University School of Nursing, president of Massachusetts Association of Registered Nurses, president of the Emergency Nurses Association, and president of the Board of Certification for Emergency Nursing. Dr. Manton has written numerous publications and presents locally and nationally on a variety of professional nursing topics. She is the recipient of numerous awards for her significant contributions to her profession. Dr. Manton is a nurse planner for Western Schools.

Nurse Planner: Amy Bernard, MS, BSN, RN-BC
Copy Editor: Dottie Terry

All individuals involved in the planning of this activity have disclosed no relevant financial relationships or other conflicts of interest related to the activity.

HOW TO RECEIVE CE CREDIT FOR THIS COURSE

- Read and study the course
- Complete the self-assessment
- Attest to having read the course materials
- Enter the course completion code found at the end of this course
- Answer the course evaluation questions
- Print your certificate of completion
Leadership and Management for Every Nurse, 2nd Edition

Author: Lynn C. Parsons, DSN, RN, NE-BC

ITEM #N1664 — 30 CONTACT HOURS

Introduction

The purpose of this course is to empower nurses who work in diverse healthcare settings to incorporate into their daily practice the comprehensive leadership and management concepts needed for efficient nursing practice. Nurses have been educated to practice professional nursing and use all of their specialized skills to care for patients. Rapid changes in health care and advances in technology require nurses to expand their repertoire of knowledge and skills to practice in today’s multifaceted healthcare environment.

Chief executive officers and top-level executives (such as vice presidents and chief operating officers) of healthcare organizations are not the only professionals who provide leadership. They have elevated visibility because of their high-profile positions within the organization, but leadership must occur at all levels of the organization.

Nurses are key players in healthcare organizations and are present 24 hours a day, 7 days a week. Nursing personnel comprise approximately 33% of personnel in hospital organizations, and this percentage may be greater in other healthcare settings, such as home healthcare agencies, long-term care facilities, and hospice organizations, to name a few. Physicians rely on nurses to have direct care knowledge, familiarity with laboratory and test results, and a relationship with family members, so that the best decisions possible are made when rendering patient care. Therefore, the nurse has an important role in the healthcare team, and he or she frequently serves as a liaison between the physician, family members, and significant others.

The role of the nurse is more comprehensive in the 21st century. In the past, nurses were more involved in “hands-on” patient care. Today, nurses work in expanded roles as leaders, managers, educators, and economists. They work with patients from the preadmission phase of hospitalization, move them through the healthcare system, and back into their home communities. Collaboration with other nurses and healthcare professionals is key to good patient health outcomes and responsible fiscal management of limited healthcare dollars.

Nurses learn leadership concepts through formal education programs and gain new knowledge through continuing education and staff development sessions. Leadership and management acumen also comes through the experience nurses gain by being involved in diverse healthcare practice settings over time. Leadership theory and principles of leadership and management are important components of expansive leadership development. Theory, when applied appropriately in the practice setting, can guide patient care practices and protocols.

As learners move through each of the fifteen chapters they will cement the knowledge they currently have and gain new knowledge. Reading and participating in the case studies and answering test questions in each chapter is recommended to augment learning. Resources at the end of the chapter are aimed at enhancing the retention of materials learned.

Chapter 1: Leading and Managing

Chapter Objective

After completing this chapter, the learner will be able to:

1. Define leadership, management, and followership as they relate to professional nursing.
2. Differentiate autocratic, bureaucratic, democratic, laissez-faire, participative, transactional, and transformational leadership styles.
3. Describe attributes of effective leaders and managers.
4. Illustrate the opportunities for leadership at all levels of an organization.
5. Explain the benefits of leadership in nursing organizations.

Overview

Nursing leadership and nursing management are two distinct concepts. Attributes of both are wonderful tools for nurses to have to work effectively with other healthcare professionals. In this chapter, nursing leadership, leadership styles, nursing management, nurse manager roles, and followership are examined relative to their importance in today’s healthcare environments. The nursing profession is one that experiences constant change in clinical practice and workplace environments and must remain responsive to the healthcare needs of consumers.

The purpose of this chapter is to enumerate the differences between, and to highlight the various roles of, the nurse leader and the nurse manager. Different leadership styles will be reviewed. The nurse’s role in organizational leadership will be explored, and nurses will learn the benefits of membership in professional nursing organizations. The importance of nurse leadership at the bedside will be highlighted in a case study.

Leadership

Leadership and management are two concepts that are often intertwined. To run effectively, every organization needs good leaders and managers. However, leadership and management are two completely different entities. Leadership is commonly defined as one person’s ability to influence others. In health care, leadership involves the use of personal traits to guide patients, families, and staff through a process to achieve goals through the collective efforts of all persons involved. Table 1-1 identifies the personal traits of effective leaders.

A leader is a person who demonstrates and exercises influence over others to guide direction over a decision or within an organization (Nagelkerk, 2006). A leader focuses on relationships, rather than on the tasks required to accomplish a goal. Leaders have three essential traits: a vision for the future, trust of colleagues and coworkers, and excellent communication skills.

Effective leaders are good listeners. Listening is the most difficult form of communication. Listening involves more than hearing. The listener must pay attention and make an effort to hear the message. Attentive listening requires time and a desire to understand what another person is saying. Leaders can make use of good listening skills to garner important information for use in their decision making (Bell & Smith, 2010).

Discussion Points: Select a one-hour time frame at work and actively listen to what is being said. Write down the main things that you heard. What did you learn about yourself?

Leadership is a reciprocal relationship between a leader and a follower. Leadership can occur between one leader and one follower, a leader and a group, or a leader and a hospital, community, or the global society. Being a leader encompasses more than an individual holding a position of authority who exerts control over subordinates. Professional nurses are leaders every day when they help patients achieve the goals in their treatment plans, help patients learn self-care (for example, administering their own insulin injections), and move patients safely through hospitalization, from preadmission to discharge. Nurses are leaders regardless of the positions they hold in their organizations. Leaders are proactive in managing issues; they do not wait for something to happen. Staff nurses must be proactive leaders in their daily practice. The excerpt in Box 1-1 supports being proactive and can be applied to the nursing profession.

Leadership Styles

There are several different leadership styles. Depending on the healthcare setting and the experience and skill level of the employee, different leadership styles have varying levels of efficacy (Reynolds & Rogers, 2003). The leader’s approach is influenced by his or her practice background and role expectations.

Autocratic Leadership

Autocratic leaders use centralized decision making, independent of the opinions of subordinates (Nagelkerk, 2006). They use power and control to direct the workforce. This leadership style works well in crisis situations, when clear direc-
TABLE 1-1: LEADER TRAITS

<table>
<thead>
<tr>
<th>Trait</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust</td>
<td>Always tells the truth, even when it involves an outcome or a decision that the receiver does not want to hear</td>
</tr>
<tr>
<td>Vision</td>
<td>Analyzes current healthcare trends and envisions a better future for health care</td>
</tr>
<tr>
<td>Integrity</td>
<td>Knows own strengths and limitations, learns from them, and takes action based on self-knowledge, honesty, and life maturity</td>
</tr>
<tr>
<td>Proactiveness</td>
<td>Takes action versus letting an event happen</td>
</tr>
<tr>
<td>Skilled interactions with employees</td>
<td>Focuses on relationships (versus tasks); coaches, mentors, and counselors</td>
</tr>
<tr>
<td>Excellent communication skills</td>
<td>Speaks openly, with no hidden agenda; does not violate confidence and readily shares appropriate information</td>
</tr>
<tr>
<td>Willingness to take risks</td>
<td>Takes educated risks toward achievement of organizational outcomes</td>
</tr>
<tr>
<td>Delegation skills</td>
<td>Delegates to free time to do non-delegable tasks; delegates to empower and groom future leaders</td>
</tr>
<tr>
<td>Change master</td>
<td>Welcomes change for the betterment of the organization</td>
</tr>
<tr>
<td>Ability to empower followership</td>
<td>Mentors and coaches followers to be leaders in the organization</td>
</tr>
<tr>
<td>Ability to motivate</td>
<td>Motivates and encourages others to achieve organizational goals</td>
</tr>
<tr>
<td>Excellent listening skills</td>
<td>Informs the leader about key pieces of information necessary to make sound decisions</td>
</tr>
</tbody>
</table>

BOX 1-1: A DEN OF LIONS

There is a story told about how lions hunt their prey. Lions have a clear strategy for hunting. The younger, stronger lions leave the den and go into the countryside, positioning themselves some distance away. The older, frailer lions leave the den and roam into the land. Other animals, on hearing the ferocious roaring, run far from the den. As the animals flee, they are caught by the young lions and are sacrificed for food. The moral of the story is clear: When hearing ferocious roaring, “run to the roar.”

(Koenner & Bunkers, 1992, p. 7)

leaders are needed. Autocratic leaders usually have lower-performing groups that require close levels of supervision. Productivity, or “getting the job done,” is needed in healthcare organizations, and using a more authoritarian leadership style leads to the success of achieving their organizational goals (Masters, 2009). A successful autocratic leader must be consistent and fair in applying rules. It is unusual to see effective autocratic leaders in today’s ever-changing healthcare environment.

Bureaucratic Leadership

Bureaucratic leader styles are closely aligned with the autocratic leadership style (Finkelman, 2012). Subordinates are motivated by outside forces, such as fear related to disciplinary action and the power of the supervisor (Kleinberg & Dirschel, 2010). The bureaucratic leader relies on organizational policies and procedures and rules set forth by upper-level administrators and takes an inflexible approach in day-to-day management decisions. The bureaucratic leader gives directions without input from others on the healthcare team and expects orders to be followed.

Democratic Leadership

Democratic leaders are more participatory and share authority with other healthcare team members. They employ a team approach, facilitate human and operating resources, and share responsibility for clinical decision making and quality improvements (Kleinman, 2004). Democratic leaders invite the opinions of subordinates and value their input in decision making for all aspects of clinical and managerial issues. They encourage each team member to work collaboratively to accomplish clinical and managerial goals. Democratic leaders use their expert power to influence and gain the respect of their team members. Furthermore, they have close, one-on-one relationships with employees.

Laissez-Faire Leadership

Laissez-faire leaders are passive and defer daily decision making to their subordinates. They do not set policy by preference or their inability to do so (Nagelkerk, 2006). They offer little information for editing or revising existing policies. Simply put, they tend to follow existing policies without question. Their teams are generally less productive than those of autocratic and democratic leaders. Employees who have laissez-faire leaders tend to become frustrated and experience low levels of job satisfaction. However, this leadership style can be useful when there are established goals and highly capable individuals who are self-directed in their practice.

Participative Leadership

Participative leaders guide workers who are responsible and like to problem solve (Yoder-Wise, 2011). Such workers like to talk about issues to reach consensus. They are motivated and like their work; however, they are not confident enough to function independent of the leader (Huber, 2010). This style is effective in healthcare organizations that promote teamwork concepts; however, it takes more time to involve others, talk with them about processes, and ask them to share their ideas. In the long run, this is best because there is a “buy-in” by nurses, which leads to their supporting professional initiatives. Staff who work effectively with a participatory leader have time to manage complex quality of care initiatives and to

work collaboratively with other disciplines to develop more elaborate, comprehensive plans of patient care.

Transactional Leadership

Transactional leaders manage the day-to-day business of the healthcare organization. They function in a caretaker role and set goals for followers (Huber, 2010). The transactional leader’s main focus is on maintaining workflow by following established policies and protocols for completing routine care practices.

Transactional leaders are described as leaders who approach their subordinates in an exchange posture, whose purpose is the exchange of one thing for another. An example of exchange posture is offering the staff member a reward of weekend days off (instead of week days) for chairing a committee to recommend changes to standardized care plans. Both parties benefit by this exchange: weekend days off for the staff member and accomplishment of a major project for the manager.

Transactional leaders are found more commonly in healthcare organizations today (Finkelman, 2012). Their focus is on accomplishing the routine work that needs to be done on the patient care unit.

Transformational Leadership

Transformational leaders guide staff to function and practice at their highest level of capability (Huber, 2010). They have charismatic personalities that inspire followers to embrace change in the organization, understand their individual roles within the organization, and take personal risks to improve their performance. Transformational leadership styles fit well with the constantly changing healthcare environment.

Transformational leaders empower others. They are self-confident, self-starters, highly motivated, honest, energetic, and committed to the organization. These leaders gain power by disseminating more power to their followers. Power, simply defined, is a person’s ability to influence others.

MANAGEMENT

Management is defined as the activities required to design, organize, encourage, and control the personnel and operational resources needed to achieve organizational outcomes (Nagelkerk, 2006). Managers focus on task completion. Simply put, they get the job done. Managers direct work groups and complete numerous managerial tasks, such as scheduling, time card completion, quality management audits, and staffing and patient assignments.

A nurse manager is a registered nurse (RN) with 24-hours a day, 7-days per week responsibility for the management of one or more patient care units. The nurse manager has a complex role that includes many different tasks, some of which require immediate attention (Nagelkerk, 2006). An example of this would be a new graduate nurse assigned to a patient who suddenly codes. The new nurse may not be experienced in managing a life-and-death situation on a general medical unit. The nurse manager would need to immediately intervene in this healthcare crisis.

The nurse manager role has many components, including determining care delivery systems; managing human, operational, and capital fiscal resources; developing and promoting staff development and continuing education programs; supporting nurse practice according to professional nursing standards; and maintaining compliance with regulatory agency guidelines (Nagelkerk, 2006). Nurse managers deal with difficult employees, use
established disciplinary policies, and follow and enforce agency policies and procedures.

Effective nurse managers are skilled in coordinating and motivating nursing staff and patient groups and maintaining a safe environment in healthcare settings. They follow and enforce the rules of the organizations for which they work. Nurse managers balance complex healthcare environments and job demands and maintain productivity and delivery of quality care to consumers in hospitals and community healthcare settings (Yoder-Wise, 2011). Table 1-2 identifies the traits of effective nurse managers. These traits are very important to the smooth running of healthcare organizations.

**Nurse Manager**

Many reasons can motivate a person to apply for and accept a nurse manager role. The person may be stimulated by a challenge to manage a unit that was unstable with constant turnover, do better work than his or her predecessor, improve working conditions for staff, or enhance quality of care initiatives—or the motive may be loyalty to the employing organization.

Other reasons that cause a person to pursue a nursing management position may be that for a higher salary to support a family, to gain management experience that supports a graduate school program focused on nursing administration, or to be held in a higher regard by family, friends, and peers. A nurse may apply for a management position because an opening suddenly occurs and the nurse executive offers an “interim” role. This unexpected role change may provide the new interim manager with an opportunity to “try on” the role before making formal application.

Effective nurse managers listen to others, are good collaborators across other professional disciplines, and are task masters. They like getting the job done, whether it is completing audits on crash cart checks every shift, completing the payroll, or attending required management meetings.

Every organization has different requirements for a person to be in a nurse manager role. In all organizations, the nurse must have an active license to practice. Hospitals frequently require experience in the specialty in which the nurse is applying to become a nurse manager. The years of experience may vary in different organizations; however, many hospitals require that the nurse hold a bachelor’s degree in nursing. In large teaching and research-intensive health systems, a master’s degree in nursing may be required or preferred, depending on the complexity of the unit.

### Nurse Manager Role

The nurse manager has a 24/7/365 responsibility. In short, this means the nurse manager is responsible for all aspects of managing the assigned unit 24 hours a day, every day of the year. In larger hospital organizations, nurse managers may have assistant nurse managers working on the opposite shift(s). The nurse manager is still responsible and accountable for the unit; however, when adequate support staff are in place, the nurse manager usually is not called at home unless a higher level situation occurs. Higher level situations may involve emergent situations, such as the sudden admission of many trauma or fracture patients from the Emergency Department (ED) as a result of a bus accident involving a high school football team. Triage of multiple patients from the ED to an Orthopedic Unit could result in needing more licensed personnel than the unit typically staffs. Another example of a situation warranting a call to the nurse manager at home may be a sudden change in the weather that would preclude staff from outlying areas to travel to the hospital. In this case, the Nurse Manager could be called in to help provide direct patient care.

Nurse managers are responsible for the day-to-day operation of their respective units, which involves every aspect of managing a patient care unit. Some of the basic functions include communicating expectations, staff development, advancing their own management skills, representing and advocating for the unit to higher levels of management, making nurse-patient care assignments, managing budgets, conducting performance evaluations, hiring new staff, enforcing disciplinary actions, terminating employees when warranted, and explaining new policies, procedures, and protocols. See Table 1-3 for a review of the nurse manager’s functions, along with examples of how nurse managers achieve the expectations associated with their roles.

### Effective Nurse Managers

Effective nurse managers must have the stamina to meet the daily challenges of their roles. They must manage the care needs of patients and their families, upper administration expectations, physician requests and patient care orders, and the needs and desires of the nursing and ancillary staff. Consumers of care are more educated than in the past, and many research their health situations on the Internet, which commonly leads them to have more questions based upon what they learned. The effective nurse manager listens to their questions and concerns and responds by answering and, at times, referring the patient or family member to other healthcare professionals who can help with their specific situations.

Another excellent characteristic that effective nurse managers will have in their repertoire of skills is clinical capabilities in the specialty fields of their assigned units (Yoder-Wise, 2011). Understanding the care complexities of patients, contributing to (standardized) plans of patient care, and allocating care-specific resources in an objective way that includes nursing, health staff, and physicians in the decision making, all contribute to the effectiveness and success of the nurse manager.

The effective nurse manager maintains safety in the workplace. This is done by following agency policy for safely disposing of hazardous materials, keeping patient care areas free from excess materials, and maintaining safe access in hallways and the main unit station. This requires the nurse manager to be a good communicator with environmental services to ensure the unit is safe for patients and healthcare staff.

Workplace safety also must be a concern for all healthcare professionals. Management and staff working together can promote safe working environments. Violence in the hospital can occur on all units; however, the ED, psychiatric, and substance abuse units are especially vulnerable. Many EDs have security personnel because they are high-volume, high traffic areas. Violence prevention programs are key to maintaining a safe workplace. Hospital personnel involved on a safety committee with middle managers and administrators can create protocols and policies that address safe working environments. Safety committee members can analyze a violent incident after an occurrence, solicit feedback from personnel present at the time of occurrence, develop prevention strategies, and revise safety policies and protocols as needed (U.S. Department of Labor, Occupational Safety & Health Administration, 2008).

Entire books and multiple journal articles have been written about safety in hospitals and other healthcare organizations. Astute nurses need to know where to access information, how to reliably surf the Internet, and when to enlist the help of hospital librarians. For example, the Agency for Healthcare Research and Quality (AHRQ) offers an excellent resource for the prevention of medical errors, which can have serious patient consequences, in many different healthcare settings.

Based upon hundreds of patient safety projects and research projects, they provide 10 evidence-based tips to prevent harmful events (U.S. Department of Health & Human Resources, Agency for Healthcare Research and Quality, 2009). Hospital nurse managers can post these evidence-based findings to help prevent adverse occurrences on their nursing units:

1. Prevent central line-associated bloodstream infections.
2. Re-engineer hospital discharges.
3. Select care delivery system for unit
4. Supports team nursing on the assigned patient care unit
5. Maintains patient standards
6. Ensures sharps containers for contaminated needles are changed weekly, or more often if needed
7. Maintains safety
8. Ensures that current standards of practice are available on the unit and that staff are aware of the standards through annual check-offs
9. Complies with regulatory agency reports
10. Maintains chart audit records that are needed for regulatory agency (The Joint Commission) visit every third year
11. Enforces agency policies
12. Holds a formal counseling session with each staff nurse about his or her medication error rate
13. Selects care delivery system for unit
14. Maintains chart audit records that are needed for regulatory agency (The Joint Commission) visit every third year
15. Selects care delivery system for unit
16. Supports team nursing on the assigned patient care unit
17. Coordinates continuing education programs through the facility’s continuing education department
18. Ensures that on-site programs are offered at quarterly programs for nurses to obtain needed continuing education for licensure
19. Good listener
20. Encourages others’ ideas

### TABLE 1-2: MANAGER TRAITS

<table>
<thead>
<tr>
<th>Trait</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Task master</td>
<td>Submits 4-week nurse staffing schedule to the nursing office by the first day of the month</td>
</tr>
<tr>
<td>Promotes safety</td>
<td>Ensures sharps containers for contaminated needles are changed weekly, or more often if needed</td>
</tr>
<tr>
<td>Maintains patient standards</td>
<td>Ensures that current standards of practice are available on the unit and that staff are aware of the standards through annual check-offs</td>
</tr>
<tr>
<td>Complies with regulatory agency reports</td>
<td>Maintains chart audit records that are needed for regulatory agency (The Joint Commission) visit every third year</td>
</tr>
<tr>
<td>Enforces agency policies</td>
<td>Holds a formal counseling session with each staff nurse about his or her medication error rate</td>
</tr>
<tr>
<td>Selects care delivery system for unit</td>
<td>Supports team nursing on the assigned patient care unit</td>
</tr>
<tr>
<td>Coordinates continuing education programs through the facility’s continuing education department</td>
<td>Ensures that on-site programs are offered at quarterly programs for nurses to obtain needed continuing education for licensure</td>
</tr>
<tr>
<td>Good listener</td>
<td>Encourages others’ ideas</td>
</tr>
</tbody>
</table>

Leadership and Management for Every Nurse

Entire books and multiple journal articles have been written about safety in hospitals and other healthcare organizations. Astute nurses need to know where to access information, how to reliably surf the Internet, and when to enlist the help of hospital librarians. For example, the Agency for Healthcare Research and Quality (AHRQ) offers an excellent resource for the prevention of medical errors, which can have serious patient consequences, in many different healthcare settings. Based upon hundreds of patient safety projects and research projects, they provide 10 evidence-based tips to prevent harmful events (U.S. Department of Health & Human Resources, Agency for Healthcare Research and Quality, 2009). Hospital nurse managers can post these evidence-based findings to help prevent adverse occurrences on their nursing units:

1. Prevent central line-associated bloodstream infections.
2. Re-engineer hospital discharges.
3. Select care delivery system for unit
4. Supports team nursing on the assigned patient care unit
5. Maintains patient standards
6. Ensures that current standards of practice are available on the unit and that staff are aware of the standards through annual check-offs
7. Complies with regulatory agency reports
8. Maintains chart audit records that are needed for regulatory agency (The Joint Commission) visit every third year
9. Enforces agency policies
10. Holds a formal counseling session with each staff nurse about his or her medication error rate
11. Selects care delivery system for unit
12. Maintains chart audit records that are needed for regulatory agency (The Joint Commission) visit every third year
13. Selects care delivery system for unit
14. Supports team nursing on the assigned patient care unit
15. Coordinates continuing education programs through the facility’s continuing education department
16. Ensures that on-site programs are offered at quarterly programs for nurses to obtain needed continuing education for licensure
17. Good listener
18. Encourages others’ ideas

Leadership and Management for Every Nurse

Entire books and multiple journal articles have been written about safety in hospitals and other healthcare organizations. Astute nurses need to know where to access information, how to reliably surf the Internet, and when to enlist the help of hospital librarians. For example, the Agency for Healthcare Research and Quality (AHRQ) offers an excellent resource for the prevention of medical errors, which can have serious patient consequences, in many different healthcare settings. Based upon hundreds of patient safety projects and research projects, they provide 10 evidence-based tips to prevent harmful events (U.S. Department of Health & Human Resources, Agency for Healthcare Research and Quality, 2009). Hospital nurse managers can post these evidence-based findings to help prevent adverse occurrences on their nursing units:

1. Prevent central line-associated bloodstream infections.
2. Re-engineer hospital discharges.
TABLE 1-3: NURSE MANAGER’S FUNCTIONS

<table>
<thead>
<tr>
<th>Nurse Manager Role Functions</th>
<th>Examples for Achievement of Role Expectations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communicates goals for patient care unit</td>
<td>Nurses will answer call lights for all patients as a priority over charting in the electronic medical record (EMR) to improve patient satisfaction with nursing care</td>
</tr>
<tr>
<td>Assigns patients to nursing staff per hospital policy and state nurse practice guidelines</td>
<td>Patients with higher acuity and more invasive procedures will be assigned to registered nurses (RNs)</td>
</tr>
<tr>
<td>Develops nursing personnel</td>
<td>Provides time for nurses to attend staff development sessions, continuing education offerings, and formal educational programs to increase their knowledge of nursing theory and nursing practice</td>
</tr>
<tr>
<td>Provides performance reviews and survey measurements</td>
<td>Completes annual performance evaluations and includes findings of survey measurements for patient satisfaction, error/incident reports*</td>
</tr>
<tr>
<td>Develops self</td>
<td>Provides guidance and mentoring of successive leader</td>
</tr>
<tr>
<td></td>
<td>Seeks all aspects of continuing education, including pursuit of advanced degrees</td>
</tr>
<tr>
<td></td>
<td>Seeks and/or maintains specialty certifications</td>
</tr>
</tbody>
</table>

*Findings of surveys should be shared with employee at the time of receipt so strategies for improvement can be made.

3. Prevent venous thromboembolism.
4. Educate patients about using blood thinners safely.
5. Limit shift durations for medical residents and other hospital staff when possible.
6. Consider working with a patient safety organization.
7. Use good hospital design principles (reduce infections by having single-bed patient rooms, fall prevention based upon well-designed rooms and bathrooms, having decentralized nursing stations that facilitate easier access to patients).
8. Measure your hospital’s patient safety culture.
9. Limit shift durations for medical residents and other hospital staff when possible.
10. Consider working with a patient safety organization.

Box 1-4 describes an example in which a nurse leader exemplifies leadership traits.

FOLLOWERSHIP

Followership is an active (versus passive), interpersonal process of participating by following a leader or manager (Nagelkerk, 2006; Yoder-Wise, 2011). Effective followership entails a set of behaviors that demonstrate cooperation, collaboration, teamwork, influence, and action with a leader.

Being an effective follower takes as much work as being a good leader. Behaviors that reflect proficient leading, managing, and following complement each other (Yoder-Wise, 2011). Principles of ideal followership are:

- displaying respect toward others
- working within the healthcare system
- using “win-win” strategies
- being proactive
- accepting differences in people

- working toward agency goals with the leader
- making decisions based on professional values
- being an effective team member when working in a group
- promoting teamwork
- recognizing the leader’s authority
- securing the leader’s trust
- achieving goals without total dependence on the leader.

The roles of leaders, managers, and followers can resemble each other. Telling the truth is a key component of being a good follower, even when the truth may not be totally welcome or what the leader necessarily wants to hear. Effective followers may ask the following questions of themselves:

- Am I a good follower?
- Do I step forward?
- Is the leader happy that I am on the team?
- Am I on board with the goals of the leader?
- Do I interact with the leader in a healthy manner? Or, do I criticize the leader?

Being an effective leader, manager, or follower requires time and focused energy. All nurses will be in a position of being a manager, leader, or follower in their careers (Yoder-Wise, 2011). Such positions as charge nurse and nurse manager are more formal positions that require greater leadership and management behaviors to establish organizational goals.

Critical Thinking Exercise

What are the characteristics of a good follower?

Response

Effective followers demonstrate independent thinking and initiative to resolve problems and issues. There are different levels of engagement for followers. Some followers will want to be actively involved in resolving an issue, whereas others may be more comfortable with offering their ideas and deferring to the nurse manager. Followers are also

BOX 1-2: CASE STUDY – STAFF NURSE LEADERSHIP

Joe was admitted to the hospital 10 days ago after sustaining multiple injuries in a motor vehicle accident. His major injuries were a fractured pelvis, multiple rib fractures, and an open femur fracture. His treatment program included analgesics for pain, activity as his condition would permit, and use of antiembolic stockings. While friends and family were visiting, Joe suddenly called his nurse to the room. He complained of chest pain and difficulty breathing. The nurse suspected that Joe had a pulmonary embolism (PE) and immediately notified the physician. Arterial blood gases were drawn and a spiral computed tomography (CT) scan was done. Further interventions were immediately taken according to protocol and Joe was transferred to the intensive care unit (ICU) for closer monitoring.

The CT scan confirmed that Joe had a PE. The nurse’s early recognition of the symptoms of PE contributed to the earliest possible intervention and could well have saved the patient’s life. The nurse had never before experienced this healthcare situation, as she had only been in practice for 9 months. She kept the family informed of their loved one’s symptoms and agreed to work a double shift because the ICU was short of staff for the night shift.

On the ICU, the charge nurse assigned Joe’s care to the nurse who cared for him on the acute orthopedic surgical unit. Joe had a quiet night and responded well to intravenous heparin therapy. When he woke the next morning, the day was calm and quiet, and the nurse and Joe were able to spend quality time together. Joe thanked his nurse by saying, “I am grateful that you were my nurse yesterday. I didn’t know what was going on. You saved my life! I can’t thank you enough.” This was a moment that both the nurse and patient will always cherish.

Discussion Questions

1. What leadership traits did the staff nurse display?
2. Why is this staff nurse regarded as a leader, despite the fact that she does not hold an executive position within the organization?
3. Why are leadership characteristics in staff important at all levels of a healthcare organization?

See Box 1-3 for answers to these questions.
Leadership and Management for Every Nurse

BOX 1-3: ANSWERS TO CASE STUDY – STAFF NURSE LEADERSHIP

1. The leader traits demonstrated by the staff nurse were:
   • Excellent communication with the patient and his family
   • Proactivity in immediately notifying the physician and initiating the treatment protocol
   • Ability to gain the trust of the patient and his family
   • Integrity and flexibility, as demonstrated by seeing a need to continue care, despite the fact that her shift was over at 11:00 p.m.
   • Leadership modeling to coworkers.
2. A person does not have to hold an executive position to demonstrate leadership. The staff nurse in this case study is regarded as a leader because of her professional behavior and her actions in dealing with this patient scenario. Her actions were independent; she did not need to be asked or told by a nurse supervisor how to manage the patient’s case or be requested to stay on to provide patient care in the ICU, which was short of nursing staff.
3. Every position in an organization is important, with its own job responsibilities. Nurse leaders are needed at the bedside. In addition, personnel who support patients, such as laundry and food services, must do their jobs equally well (clean linens promote patient health and patients need to have their special dietary needs met). Hence, the roles of many personnel are extremely important in the business of providing quality patient care.

BOX 1-4: CASE STUDY – LEADER OR MANAGER?

Carol is the nurse manager of a 42-bed general and peripheral vascular surgical unit. Carol has been the nurse manager of this unit for 9 years. Her unit is known for the delivery of quality nursing care by cheerful nurses, several of whom are staff nurses with longevity. The unit employs new nurses and very seasoned nurses with several years of nursing experience. Today, Carol is assisting a new associate degree registered nurse (RN) complete her application to a baccalaureate degree nursing program. She has just promoted one of her night-shift staff nurses to the full-time afternoon shift charge nurse position. She has delegated responsibility for implementing a new electronic charting system to another highly experienced RN. Carol frequently makes rounds on the unit each day, ensuring that patient needs are being met. During rounds, Carol commonly asks the nursing staff about their family members and events experienced RN. Carol frequently makes rounds on the unit each day, ensuring that patient needs are being met. During rounds, Carol commonly asks the nursing staff about their family members and events.

Discussion Questions
1. Does Carol exhibit leadership or management behaviors?
2. Depending on your answer to question #1, what leader or manager traits does she exhibit?
3. Are any of the staff nurses on the general and peripheral vascular surgical unit leaders?

See Box 1-5 for answers to these questions.

BOX 1-5: ANSWERS TO CASE STUDY – NURSE LEADER OR MANAGER?

1. Leadership. Although she is a manager, Carol also clearly exhibits leadership behaviors. Management and leadership behaviors are not always inclusive of one another, but in this case, they are.
2. Carol exhibits the following traits:
   • motivates and encourages her staff to (a) assume positions of higher authority (staff nurse to charge nurse) and (b) obtain further formal education for a nursing degree.
   • exhibits skillful interactions with employees.
   • displays excellent communication skills and good delegation skills.
3. Yes. Leaders are cooperative and collaborative with whom they work. Leaders can be followers when another person’s skill set is greater in a certain area. The nurses on Carol’s unit exemplify leadership by taking on more responsibility (transitioning from staff to charge nurse) and by being proactive and furthering education.

STAFF NURSE LEADERSHIP

Serving on a unit task force or committee in one’s work setting and interacting with other nurses and healthcare professionals facilitates the learning of leadership skills. Serving on program, education, and other committees within a healthcare organization can bring their knowledge, skills, and desire to help others into their communities.

Staff nurses can also serve the profession by being members of their professional organizations. Most professional organizations have a “Willingness to Serve” form for the members to complete, which promotes a great way to learn leadership skills and takes participants to the next level. This can be accomplished by serving on a local, regional, national, or international committee. Many professional organizations have “Special Interest Groups” that have a large number of members, which is a good way for nurses to get a foot in the door and become known to leaders in the organization. It is most often recommended that nurses begin to develop leadership skills in professional organizations at the local level because it allows for increased mentoring opportunities for leadership development. Later, the staff nurse can volunteer to serve on a larger committee. Some of these committees include program planning (for the next annual conference or mid-year continuing educational offerings), research, editorial boards, or leadership succession committees, to name a few. Different professional organizations will have varying opportunities to serve on task forces, editorial boards, manuscript review panels, and many different committees. Being visible in the public eye brings recognition to nurses and their employers.

LEADERSHIP IN PROFESSIONAL ORGANIZATIONS

One of the best routes for a nurse to take to garner leadership skills is to join a professional nursing organization (Catalano, 2012; Yoder-Wise, 2011). Organizational leadership is a process of gaining leadership skills and attributes through involvement in professional nursing organizations. The American Nurses Association (ANA) represents the professional interests of the over 3 million RNs in the U.S. as well as in Puerto Rico and U.S. territories. The ANA is a full-service professional nursing organization (ANA, n.d.). New graduate nurses are encouraged to join the ANA. Within the ANA, running for an elected office at the district or state level can eventually lead to a position of greater responsibility at the state or national level. If nurses are not successful in their first bids for elected office, they should run again. Losing an election can still have a positive outcome by getting a nurse’s name in the public eye—a plus for when the nurse runs for election at a future date.

Many staff nurses gain leadership knowledge through active involvement in ANA state associations and task forces or at local levels (Yoder-Wise, 2011). A major benefit for employer healthcare organizations is that the nurse leader will bring back new knowledge and expertise to the organization. Actively involved staff nurse leaders can impact policy revisions and patient care protocol changes within their organizations. Another way to gain tremendous leadership skills and visibility is to serve as a delegate at a state or national meeting.

By joining the state nurses’ association, a nurse is indirectly a member of the ANA. Discounts are available for new members and new graduate nurses. Retired nurses and nurses who practice part-time enjoy reduced rates for membership (Catalano,
Professional Specialty Organizations

Nursing specialty organizations provide expert clinical knowledge in a focused clinical field. There are many different nursing clinical specialty-, research-, and leadership-focused nursing organizations in the United States. According to the American Nurses Credentialing Center (ANCC, 2013), more than 135,000 nurses have received specialty certification through the ANCC since 1991. The ANCC administers nearly 40 specialty and advanced practice certification examinations each year. In addition, many nursing specialty organizations offer certification in their respective specialties.

Membership in such organizations affords leadership opportunities in the nurse’s focused interest area. Additionally, nurses gain leadership opportunities to give platform presentations at local, state, regional, national, and international forums as well as to develop and impart information in poster presentation formats.

Joining professional nursing organizations facilitates networking among colleagues from all over the country and around the world. Professional networking is a continuous means of initiating and continuing relationships through communication and information sharing. Shared collaboration outside of the nurse’s place of employment gives a broader perspective on healthcare issues in general and in specialty areas (Frank, 2005). Membership in professional nursing organizations gives the nurse a competitive edge through current knowledge, cutting-edge technologies, activism, and a connectedness with peers from across the globe.

Certification

Another major benefit of active membership in nursing specialty organizations is becoming a certified nurse. As previously mentioned, many nurses in the United States pursue specialty certification. Certification signifies knowledge in a nursing specialty field beyond RN licensure (Frank, 2005). Certification is voluntary, and there are many ways of obtaining and maintaining certification. A nurse usually obtains initial certification by passing the specialty organization’s examination. Certification is maintained through different venues, depending on the certified field; examples include continuing education units, retesting, formal courses, publication, and professional presentations (ANCC, 2013). Certification signifies to healthcare professionals and the general public that nurses have advanced knowledge and expertise above what was taught in their formal education programs. In some clinical settings, nurses receive a stipend for certification. In other organizations, nurses receive a salary increase. Certification is a method to improve competencies beyond basic nurse generalist preparation and demonstrates a nurse’s willingness to be proactive in the forward movement of his or her career trajectory.

Chapter 2: Delegation

After completing this chapter, the learner will be able to describe delegation principles utilized in nursing practice.

Learning Objectives

After studying this chapter, the learner will be able to:
1. Define terminology related to nurse delegation.
2. Use the delegation decision-making model to make delegation decisions.
3. List the five rights of delegation.
4. Determine the authority of a nurse to delegate by using state nurse practice act guidelines.
5. Differentiate between direct and indirect delegation.
6. Identify common delegation pitfalls.
7. Explain the importance of proficient delegation skills needed for nursing practice.

Common Terms

Advanced Practice Registered Nurse (APRN) – a person who performs additional acts through specialized knowledge and clinical skills gained through organized post-basic educational programs of study. These individuals are certified by the American Nurses’ Credentialing Center (ANCC) or other nationally established organizations that are recognized by boards of nursing that certify registered nurses (RNs) as advanced practice nurses (APNs).

Assignment – work distribution for staff members during an assigned shift.

Delegate – the person to whom a delegated activity is directed.

Delegator – the person who delegates an activity.

Scope of Practice – procedures, actions, and processes that are permitted for the licensed individual and are determined by state boards of nursing.

Overview

The ability of nurses to understand the delegation process is extremely important in today’s healthcare environment. Delegation concepts are now being included on nurse licensure examinations. The nationwide shortage of registered nurses (RNs) makes delegation an important skill because the workforce is comprised of many different levels of caregivers. Nurses must skillfully delegate to a lesser-skilled workforce, which commonly includes several types of unlicensed assistive personnel (UAP). The term unlicensed assistive personnel refers to healthcare workers who are not licensed but are prepared to provide certain elements of patient care at the direction of an RN or other licensed professional caregiver. Unlicensed assistive personnel include certified nursing assistants, patient care technicians, and home health aides as well as various types of unlicensed technicians (techs) who perform specific tasks as directed (e.g., electrocardiograms).

Delegation is a skill that can be taught and learned by nurses. It is imperative that nursing schools’ curricula address delegation in their didactic and clinical courses. Delegation proficiency is an important skill for nurses to learn while still in nursing school. It is just as important as learning the psychomotor skills of inserting a urinary catheter, starting an intravenous (IV) line, and completing tracheostomy care. The concept of delegation must be addressed early in nurses’ careers because nurses are faced with the need to delegate effectively within the boundaries set by their state nurse practice acts (laws guiding practice), as soon as they enter the workforce as graduate RNs. Nurse delegation has emerged as an issue and skill of importance because of increased patient acuity.

The purpose of this chapter is to define nurse delegation and terminology related to delegation. The differences between direct and indirect delegation will be explored. Guidelines provided by the National Council of State Boards of Nursing (NCSBN) and individual state nurse practice acts will be examined because they provide direction for delegation in nursing practice. Case studies will be employed to exemplify nurse delegation decision making.

Delegation

Delegation is a concept that is more prevalently discussed in nursing today than it was 20 years ago. The NCSBN defines delegation as “transferring to a competent individual authority to perform a selected nursing task in a selected situation” (National Council of State Boards of Nursing [NCSBN], 2005, p. 1). Similarly, the American Nurses Association (ANA) defines delegation as “the transfer of responsibility for the performance of a task while retaining accountability for the outcome” (American Nurses Association [ANA], 2005, pg. 4).
Approximately 97% of hospitals employ assistive personnel (AP), who carry such titles as nursing assistant, patient care technician, and care partners (Clark, 2009). This level of workers permeates the healthcare industry, and it is important that the nurse know how to safely delegate care to AP.

Many state nurse practice acts specifically address delegation activities for RNs (Henderson et al., 2006; Porter-O’Grady & Malloch, 2013). Other states address delegation under the umbrella of supervision. Delegation is an important concept that the nurse should be knowledgeable of to effectively deliver safe patient care (ANA, 2005). Many years ago the ANA and the NCSBN developed a collaborative document about delegation. Nine principles were emphasized, which can be accessed on the ANA and NCSBN Websites.

The nine principles encompass:
1. Professional responsibility and accountability
2. Use of UAP and patient care coordination
3. Delegation parts of the nursing process to UAP
4. Importance of professional nursing judgment
5. Delegating to capable people
6. Effective communication strategies between the RN and the delegate
7. Importance of two-way communications between the delegator and the delegate
8. Importance of clinical judgment, critical thinking, and the five rights of delegation
9. Nurse Executive’s role in ensuring sufficient support for the delegation process

(ANA/NCSBN, 2005).

All practicing nurses should review their individual state nurse practice acts for specific guidance on nurse delegation. It is especially important to know practice act guidelines when working on mixed teams with caregivers of varying skills, education, and experience.

Nurses must assess the mix of staff to determine appropriate delegation. Matching nurses to tasks, based on complexity, expertise, individual strengths, knowledge levels, interests, and skill competency, is extremely important for safe delegation (Barker, Sullivan, & Emery, 2006). Knowledgeable RNs quickly learn the capabilities of delegates, while maintaining accountability for patient care outcomes. Soliciting the input of team members about delegated activities facilitates staff input into assignment decisions and can enhance morale. The delegate is responsible for performing the role functions outlined in his or her position description. Finally, proper delegation can increase job satisfaction, enhance retention in the workforce, and enhance the image of nursing to society. Nurses satisfied in their roles are more likely to portray the public a positive representation of the role of the nurse within the healthcare system.

Nurses are responsible for patient care outcomes when delegating to licensed practical nurses (LPNs), licensed vocational nurses (LVNs), and UAPs (Sheehan, 2001). Nurses are liable if they delegate care knowing that the delegates cannot competently perform the tasks. The NCSBN (1997) developed the “Five Rights of Delegation” to provide guidance in making delegation decisions to lesser skilled team members. These rights of delegation are listed and described in Table 2-1.

### TABLE 2-1: FIVE RIGHTS OF DELEGATION

<table>
<thead>
<tr>
<th>Delegation Right</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Right task</td>
<td>Tasks can be delegated for specific patients as long as each task is within the delegate’s position description and covered by organizational policy, procedures, and protocols. The limits of the activities to be performed must be delineated.</td>
</tr>
<tr>
<td>Right circumstance</td>
<td>The complexity of the activity must be within the scope of practice for an LPN or LVN or within the position description for a UAP, and appropriate supervision of the activity must occur.</td>
</tr>
<tr>
<td>Right person</td>
<td>The nurse must ensure that standards of practice, licensure laws, educational requirements, and competency requirements for delegates are met before delegation of tasks. All nursing personnel must take responsibility for their own professional development and continuing education.</td>
</tr>
<tr>
<td>Right direction/communication</td>
<td>The nurse must provide definitive communication of expectations, whether written, oral, or direct care delivery. A clear description of the task, the expected outcome, limitations, and expectations must be communicated to the delegate.</td>
</tr>
<tr>
<td>Right supervision</td>
<td>The nurse must provide monitoring and intervene as needed, including employee evaluation and feedback.</td>
</tr>
</tbody>
</table>

(ANA/NCSBN, 1997)

**Terms Associated with Delegation**

The RN is liable for patient care and must be familiar with all aspects of delegation. Common terms used in relation to delegation include responsibility, authority, and accountability.

**Responsibility**

Responsibility simply means that a person is capable of being depended on (Yoder-Wise, 2011). Every person employed in a healthcare agency has a position description and items within that document are the responsibility of the employee. Responsibilities increase with a person’s level of education, experience, and demonstrated capabilities (Kelly-Heidenthal, 2003).

**Authority**

Delegation of duties places the RN in an authority position. Authority is the right to give directives to others and expect compliance from subordinates (Yoder-Wise, 2011; Kelly-Heidenthal, 2003). Nurses have the authority to delegate based on state nurse practice acts and through policies and protocols established by their employing agencies. When other members of the team view the RN with respect, a good working environment and teamwork result.

**Accountability**

RN’s are accountable at all times for their actions, and this accountability cannot be delegated. Nurses are also accountable for ensuring the integrity of the nursing process (the scientific problem-solving process for patient care). Nurses must follow their respective state nurse practice acts, standards of professional nursing practice, and the policies and protocols of their employing healthcare agencies (Huber, 2010; Kelly-Heidenthal, 2003). Certain components of the nursing process cannot be delegated to UAP. For example, patient assessment and care planning are skills that require the knowledge of an RN. Assisted personnel are delegated care activities within the implementation phase of the nursing process. Some basic care procedures that can safely be delegated to UAP are bathing, assisting with walking, answering call lights, passing snacks, and assisting with meals.

**EVIDENCE-BASED PRACTICE AND NURSE DELEGATION**

Seminal research completed by Conger (1993) supports that nurse delegation is a skill that can be taught and put into practice by RNs. The current shortage of nurses mandates that nurses be knowledgeable of delegation principles and practices outlined in individual state nurse practice acts.

Qualitative research conducted by Bittner and Gravlin (2009) studied how nurses made decisions associated with delegating care procedures to UAP. The study participants were nurses practicing on general medical-surgical units. They were asked to share clinical situations in which they delegated activities that were successful and unsuccessful. As a final point in the investigation, participants were asked about care omissions. The study resulted in seven classifications being determined that related to delegation: tasks delegated, knowledge expectation, relationships, role uncertainty, communication barriers, system support, and omitted care. Nurses were unclear whether the UAP understood expectations of the delegated tasks or if the delegated tasks were accepted by the UAP. Lack of follow-up by the nurse through the course of the shift often resulted in learning important information at the end of shift report. Exacerbating this situation was a shortage of unit clerk staff and lack of equipment and needed supplies. Findings from the Bittner and Gravlin research support that some patient care was missed or omitted, which adversely affected quality care provision.

Kinjerski and Skrypnek (2008) conducted an investigation with staff in a long-term care facility that found work connectedness (meaning tasks are linked to each other, such as giving pain medication and assessing for pain relief) and positive patient outcomes correlated with increased teamwork, increased job satisfaction, and decreased absenteeism. This research supports that correct delegation of tasks has positive outcomes for patient care and the nurse’s job satisfaction.

Another study conducted by Reinhard, Young, Kane, and Quinn (2006) reviewed delegation practices by RNs to UAP in assisted living units in...
long-term care facilities. Qualitative interviews were conducted by board of nursing executives across the United States to validate a legal summary for assisted living regulations and all state nurse practice acts. Findings from the interviews helped to determine issues relative to medication management. Considerable variations were identified in the roles of the RNs and UAP relative to medication administration. Mechanisms for determining the quality of the delegation process were not in place while this study was conducted. Of concern is that the study found that there is inadequate communication of medication policies between assisted living units in long-term care facilities.

Data-based evidence supports that appropriate nursing supervision, delegation of tasks, appropriate communication, and care prioritization can improve patient care outcomes, enhance employee job satisfaction, and decrease absenteeism and the costs associated with covering staff vacancies (LaCharity, Kumagai & Bartz, 2011). Additional research needs to be conducted to determine best practices relative to nurse delegation in all practice settings. Best practices relative to nurse delegation decision making should be based upon evidence-based findings.

**Delegation Models**

Delegation models guide nurse decisions for delegation. Two delegation models in the nursing literature are reviewed here.

**Delegation Decision-Making Model**

Conger’s (1993) Delegation Decision-Making Model (DDMM) provides guidance to RNs for delegation in practice. A schematic representation of the DDMM is presented in Figure 2-1. This framework emerged in the nursing literature in the mid-1990s and directs the RN to identify procedures and patient problems. After determining the patient’s specific care needs and identifying the patient’s problems, the third and last step guides the nurse to make an assignment decision based on education level, position description, healthcare agency policy, licensure laws, and demonstrated capabilities (Parsons, 2004). By following the steps within the model, the nurse reaches a delegation decision based on objective criteria.

The Nursing Assessment Decision Grid (NADG) is the tool used to document patient tasks, problems, and the level of caregiver needed to deliver patient care (Conger, 1993, 1994). When determining the level of caregiver needed, items rated as a “3” require RN intervention, items rated as a “2” can be delegated to an LPN or LVN under the supervision of an RN, and items rated as a “1” can be delegated to an LPN or LVN independently. Box 2-1 presents a case study for the learner to determine what tasks and procedures need to be done for a patient with a spinal cord injury. Based on the level of caregiver needed for the patient, the charge nurse can make an informed assignment decision. This case makes the nurse think about delegation and the documents that can assist with delegation in practice. After putting the information on the NADG, the nurse’s confidence with using the tool is enhanced.

Other studies have adapted the tool and assigned UAP to items rated as a “1” (Parsons, 2004). When this is done, agency policy, position description, and the demonstrated ability of the UAP must be documented.

---

**FIGURE 2-1: DELEGATION DECISION-MAKING MODEL**

<table>
<thead>
<tr>
<th>Identify Required Tasks</th>
<th>Identify Patient Problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>• ordered by the MD</td>
<td>• biological</td>
</tr>
<tr>
<td>• ordered by the RN</td>
<td>• psychosocial and spiritual</td>
</tr>
<tr>
<td>• mandated by agency policy</td>
<td></td>
</tr>
</tbody>
</table>

Evaluate Most Appropriate Staff Member

- education
- job description
- hospital (agency) policy
- licensing legislation
- demonstrated competency

Make a Delegation Decision


---

**Decision-Making Process Model**

The NCSBN (2005) developed a decision-making model that mirrors the nursing process (assess, plan, implement, and evaluate). This model assists nurses in using their clinical judgment when delegating tasks to lesser-skilled team members. The six steps of the model are:

1. assess the clinical circumstances
2. determine the tasks that can be delegated safely
3. assume accountability for delegated tasks
4. provide appropriate supervision relative to delegated tasks
5. evaluate the complete delegation process
6. continually reassess the circumstances and make suitable adjustments in the overall plan of care.

Following the steps outlined in the model ensures safe practice and appropriate delegation. Additionally, proper delegation promotes safety and diminishes potential liability (Marquis & Huston, 2006).

**Working with UAP**

RNs and LPNs are ultimately responsible for care delivery by UAP (Cox, 2006). The patient’s condition may determine whether a UAP can deliver care. Cox (2006) points out that changing the bed linens is noninvasive and can be safely delegated to UAP. However, if for example, a patient is morbidly obese and recovering from an invasive procedure, or a frail elder, the circumstances might be such that a licensed nurse must work with the UAP or actually deliver patient care.

As leaders, nurses’ appropriate delegation can motivate and cultivate the skills of UAP. Assigning only aspects of care that a nurse finds unpleasant or boring can deter UAP job satisfaction and devalue their work on the team (Cohen, 2004). It is important for nurses to work with all team members to assess their capabilities and build their care delivery skills. Finally, praise of the work done by UAP goes a long way in making them feel like valued, respected team members. An example of nurses working with UAP is depicted in Box 2-4. The case is reflective of a UAP not taking responsibility for an assignment within the scope of the job description.

**SCOPE OF PRACTICE**

Scope of practice can vary within a state. The roles and scope of practice for advanced practice nurses (APRNs), RNs, and LPNs will be examined.

**Advanced Practice Nurses**

The use of APRNs began in the 1960s as a result of shortages of primary care physicians in different geographic areas. Limited access to care, especially in rural areas with underserved cohorts, contributed to positive reactions of APRNs serving as primary care providers. This created a chasm when physicians desired APRNs to accept activities delegated by them, versus having independent practice (U.S. Congress, Office of Technology Assessment, 1986). Some states increased the APRNs’ scope of practice, thereby creating greater practice autonomy (Cooper, 2007). Other states do not hold this view, which contributes to the lack of APRN practice standardization relative to nurse delegation.

Despite critical shortages of healthcare practitioners, specifically primary care providers, state nurse practice acts continue to limit the scope of APRN practice (McInnis & Parsons, 2009). Approaches by individual states to licensure and scope of practice inhibit care delivery by APRNs. To ensure that delegation is a successful strategy, physicians need to expand their knowledge of APRN capabilities and scope of nursing practice.
What documents can assist a nurse in making delegation decisions?

To what level of caregiver could the RN assign this patient? Explain your answer.

1. Identify the tasks, procedures, and problems for this patient.

Box 2-2.

He is being managed on Keflex, 1g IV every 6 hours. Because of dehydration, he has an IV of dextrose 5% in half-normal saline solution infusing at 100 mL/hour. His medications include Dilutran 5 mg po TID, vitamin C 500 mg po BID, Peri-Colace 100 mg po BID, Ducolax suppository per rectum with dilution procedure every other day at 9:00 p.m., and Tylenol 500 mg every 4-6 hours prn.

Mr. Jones is somewhat “down” because his wife cannot visit because of postoperative discomfort. He asks the nurse to unplug his bed so he can have a cigarette.


Discussion Questions:

Write your answers on a separate piece of paper, then compare your responses to those in Box 2-2.

1. Identify the tasks, procedures, and problems for this patient.
2. Determine whether an RN, LPN, or UAP can accomplish each task or problem. Assign a rating of 1, 2, or 3.
3. To what level of caregiver could the RN assign this patient? Explain your answer.
4. What documents can assist a nurse in making delegation decisions?

See Box 2-2 for answers to these questions.

Box 2-2: ANSWERS TO CASE STUDY – MR. JONES

1. The completed nursing assessment outlining the patient’s tasks and problems are identified on the completed NADG in Box 2-3.
2. The completed NADG ratings are listed in the right-hand column under “Rating” on the grid in Box 2-3.
3. An RN or an LPN (with supervision of an RN) could be assigned to this patient. The state in which the care is being delivered may impact the RN’s assignment decision. If the state nurse practice act has written guidelines for invasive procedures that would allow an LPN or LVN to administer IV medications, the RN may assign the patient to an LPN or LVN and supervise as needed. As with any paper-and-pen case study, there are always outside circumstances that can impact a delegation decision.
4. Several documents can assist a nurse in making delegation decisions, including:
   a. Agency policies
   b. State nurse practice acts
   c. Position descriptions
   d. Five Rights of Delegation from NCSBN web site (http://www.ncsbn.org)
   e. School of nursing curricula
   f. Conger’s DDMM.

Licensed Practical Nurses

LPN scope of practice is also delineated in individual state nurse practice acts. LPNs are generally recognized for delivery of basic nursing care by performing skills taught to them in approved practical nursing programs.

As an example, the Kentucky Board of Nursing Scope of Practice Determination Guidelines for RNs includes:

a. The care, counsel, and health teaching of the ill, injured or infirm.
b. The maintenance of health or prevention of illness of others.
c. The administration of medication and treatment as prescribed by a physician, physician assistant, dentist, or advanced practice nurse and as further authorized or limited by the board, and which are consistent with the American Nurses Association Standards of Practice or with standards of practice established by nationally accepted organizations of registered nurses.

Components of medication administration include, but are not limited to:

1. Preparing and giving medication in the prescribed dosage, route, and frequency;
2. Observing, recording, and reporting desired effects, untoward reactions, and side effects of drug therapy;
3. Intervening when emergency care is required as a result of drug therapy;
4. Recognizing accepted prescribing limits and reporting deviations to the prescribing individual;
5. Recognizing drug incompatibilities and reporting interactions or potential interactions to the prescribing individual; and
6. Instructing an individual regarding medications. (Kentucky Board of Nursing, 2011b, Para 3).

Learners are encouraged to access their state nurse practice acts and review their scopes of practice to gain knowledge and understanding of the guidelines for practice set forth by their state of residence.
**BOX 2-3: COMPLETED NURSING ASSESSMENT DECISION GRID FOR MR. JONES**

<table>
<thead>
<tr>
<th>TASKS IDENTIFIED</th>
<th>RATING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission/Physical Assessment</td>
<td>3</td>
</tr>
<tr>
<td>Care Plan/Critical Pathway</td>
<td>3</td>
</tr>
<tr>
<td>Medication Administration (dilation procedure)</td>
<td>2</td>
</tr>
<tr>
<td>Vital Signs</td>
<td>1</td>
</tr>
<tr>
<td>Activities of Daily Living</td>
<td>1</td>
</tr>
<tr>
<td>Force Fluids</td>
<td>1</td>
</tr>
<tr>
<td>Maintain IV Drip Rate</td>
<td>2/3*</td>
</tr>
<tr>
<td>Intravenous Piggybacks (antibiotics)</td>
<td>2/3*</td>
</tr>
<tr>
<td>Intake &amp; Output</td>
<td>1</td>
</tr>
<tr>
<td>Intermittent Catheterization</td>
<td>2</td>
</tr>
<tr>
<td>Therapeutic Communication</td>
<td>1</td>
</tr>
<tr>
<td>Psychosocial Status Assessment</td>
<td>3</td>
</tr>
<tr>
<td>Dressing Changes</td>
<td>2</td>
</tr>
<tr>
<td>Teaching (diet, smoking cessation)</td>
<td>3</td>
</tr>
<tr>
<td>Splint Chest/Assist with Cough &amp; Deep Breathing</td>
<td>2</td>
</tr>
<tr>
<td>Respiratory Assessment</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PROBLEMS IDENTIFIED</th>
<th>RATING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>2/3</td>
</tr>
<tr>
<td>Non-Intact Integument</td>
<td>2</td>
</tr>
<tr>
<td>Paralysis</td>
<td>2</td>
</tr>
<tr>
<td>Grief (r/t loss of brother and wife’s health status)</td>
<td>2</td>
</tr>
<tr>
<td>Gastrointestinal Dysfunction Secondary to SCI</td>
<td>2</td>
</tr>
<tr>
<td>Bladder Dysfunction Secondary to SCI</td>
<td>2</td>
</tr>
<tr>
<td>Reflexia (potential for autonomic hyperreflexia)</td>
<td>2</td>
</tr>
<tr>
<td>Sexual Dysfunction</td>
<td>2/3*</td>
</tr>
<tr>
<td>Under nutrition</td>
<td>3</td>
</tr>
<tr>
<td>Respiratory Dysfunction Secondary to SCI</td>
<td>3</td>
</tr>
<tr>
<td>Discharge Planning</td>
<td>3</td>
</tr>
</tbody>
</table>

**DECISION PROCESS**

Items rated as a 3 require RN intervention.

Items rated as a 2 can be delegated to an LPN or LVN (level) under RN supervision or require the LPN to be taught.

Items rated as a 1 can be done by an LPN or LVN (level) and/or delegated to a UAP (level) depending on job description, agency policy, and demonstrated competence.

* An LPN or LVN may perform/intervene for a task/problem category if the individual state nurse practice act has written guidelines in the laws governing LPN practice.

**SCORING**

There are a total of 16 tasks/procedures, 11 problems identified, and 27 ratings for the level of caregiver required (16 + 11 = 27). Therefore, the total possible points in this case study is 54.


as authorized by a physician, physician assistant, dentist, or advanced practice registered nurse and as further authorized or limited by the board which is consistent with the National Federation of Licensed Practical Nurses or with standards of practice established by nationally accepted organizations of licensed practical nurses.

d. Teaching, supervising, and delegating except as limited by the board.

e. The performance of other nursing acts which are authorized or limited by the board and which are consistent with the National Federation of Licensed Practical Nurses’ Standards of Practice or with standards of practice established by nationally accepted organizations of licensed practical nurses. (Kentucky Board of Nursing, 2011a, Para 2)

When nurses read the practice act, they readily know the permitted and prohibited functions for LPN practice. The following are permitted functions of the LPN in Kentucky:

- calculation and adjustment of flow rates on all IV infusions
- observing and reporting adverse reactions and initiating interventions
- for all types of access devices:
  1. administration and discontinuation of IV fluids and medications (except as limited and under supervision as required)
  2. performance of site care
  3. performance of maintenance care
- 4. conversion from continuous to intermittent infusion
- 5. IV fluids and medications must be premixed and labeled by an RN, MD, dentist, or pharmacist or commercially prepared
- insertion and removal of peripheral route access devices only
- administration, maintenance, and discontinuance of blood, blood components, and plasma volume expanders
- when giving via push or bolus route, can administer ONLY: analgesics, antiemetics and their antagonistic agents; diuretics; corticosteroids; glucose (to patients 14 years of age and older); and saline or heparin flush
- administration, maintenance, and discontinuance of select medications and fluids via a patient controlled administration system
- administration of parental nutrition and fat emulsion solutions
- performance of dialysis treatments, including administering heparin 1:1000 units or less concentration either to prime pump, initiate treatment, or administration throughout treatment per order of the physician, physician’s assistant, or advanced practice registered nurse; also, administering normal saline via the dialysis machine to correct dialysis-induced hypotension based on facility protocol
- collection of blood specimens from a peripheral IV access device
- removal of a noncoring needle from an implanted venous port
- titration of IV analgesic medications for hospice patients
- administration of IV medications or solutions via a ready to mix IV solution infusion system
- aspiration of a central venous catheter to confirm patency via positive blood return (Kentucky Board of Nursing, 2011a).

The following are prohibited functions of the LPN in Kentucky:

- administration of tissue plasminogen activators, immunoglobulin, antineoplastic agents, and investigational drugs
- accessing of central venous devices used for hemodynamic monitoring
- administration of medications or fluids via arterial lines or implanted arterial ports
- all fluids and medications via a push or bolus route except those specifically listed in the permitted section
- administration of fibrinolytic or thrombolytic agents to declot any IV access device
- administration of medications requiring titration except for those listed in the permitted section
BOX 2-4: CASE STUDY – DELEGATION BETWEEN AN RN AND A UAP

An RN on a general medical-surgical unit in Brighton City Community Hospital is working with a UAP whom she has known and worked with for the past 6 months. Today, she delegates the task of taking vital signs for all patients on the 18-bed unit. She gives specific instructions to take vital signs for Mrs. Carlson on her left arm because the patient has had a right radical mastectomy with lymph node removal. After the UAP received instructions from the RN, she said she understood the directives and began the assignment. The Kardex outlining care guidelines included that vital signs, including blood pressure (BP), be taken on Mrs. Carlson’s left arm. Additionally, the instructions for the patient’s vital signs were documented on a sign above her bed. The UAP received a unit orientation upon hire that addressed taking vital signs with special instructions. Furthermore, she received a satisfactory 90-day probationary evaluation, which is consistent with hospital policy. During rounds, the RN finds Mrs. Carlson in bed with the BP cuff fully inflated on her right arm. The UAP cannot be found.

This is an occurrence that happens all too often in hospitals. The issues in this case study need to be analyzed.

Discussion Questions
1. What is the RN accountable for in this case study?
2. Did the RN delegate correctly? Defend your answer.
3. Is the RN’s license “on the line” for working with a UAP who performed an incompetent act?
4. What is the UAP responsible for in this case study?
5. What steps can a busy RN take to promote correct and safe delegation decisions in practice?

See Box 2-5 for answers to these questions.

BOX 2-5: ANSWERS TO CASE STUDY – DELEGATION BETWEEN AN RN AND A UAP

1. The RN is accountable for safe patient care.
2. Yes. The following reasons support that the RN delegated appropriately:
   a. Taking vital signs with special precautions is within the position description of the UAP.
   b. The RN worked with the UAP for 6 months, so she was aware that this assignment was within the capabilities of the UAP.
   c. The UAP had a satisfactory 90-day probationary evaluation. The delegated task was well within the parameters of the UAP position description.
   d. The UAP verbalized understanding of the assignment.
   e. The special precautions were well documented and in plain view of the UAP.
3. No. The RN delegated appropriately.
4. The UAP is responsible for completing tasks within the hospital position description.
5. The RN should periodically inspect the tasks that are delegated and provide feedback to the delegate. The RN should provide praise and recognition when appropriate.

• insertion or removal of any IV access device, except a peripheral route device
• accessing or programming an implanted IV infusion pump
• administration of IV medications for procedural sedation or anesthesia
• administration of medication or fluids via an epidural, intrathecal, intraosseous, or umbilical route or via a ventilator reservoir
• administration of medication or fluids via an arteriovenous fistula or graft, except for dialysis
• repair of central venous route access devices
• mixing of any medication except those listed in the permitted section
• insertion of a noncoring needle into an implanted port
• performance of therapeutic phlebotomy
• administration of medications or fluids via a percutaneously or surgically inserted non-tunneled, non-implanted central venous catheter
• aspiration of an arterial line
• withdrawal of blood specimens via a central, midclavicular, or midline catheter
• initiation and removal of a peripherally inserted central, midclavicular, or midline catheter (Kentucky Board of Nursing, 2011a).

Reviewing the permitted and prohibited functions associated with the role and scope of practice for LPNs in Kentucky gives the learner a picture of what can and cannot be performed by the LPN. Registered nurses need to familiarize themselves with the scope of practice guidelines for RN and LPN practice according to their state nurse practice acts.

DIRECT AND INDIRECT DELEGATION

Direct Delegation

Direct delegation is straightforward and involves verbal directives of an RN to subordinate team members (Kelly-Heidenthal, 2003; Turk, 2009). When the nurse offers appropriate feedback to staff, their performance and team thinking processes improve (Kozlowski & Ilgen, 2007). It is the responsibility of the RN who delegates a task to inquire about progress being made toward the delegated task or goal. The manager who delegates a task should help remove barriers to task completion, periodically follow-up with the delegate, and offer praise for a job well done (Roussel, 2013).

Indirect Delegation

Indirect delegation occurs when the delegate completes tasks based on policy, approved procedures (documented in a procedures book), or agency protocols. Examples of indirect delegation by agency policies, protocols, or approved procedures include such actions as routine vital signs and measuring intake and output.

DELEGATION PITFALLS

Under delegation, over delegation, and improper delegation are common delegation errors that occur in nursing practice (Kelly-Heidenthal, 2003; Marquis & Huston, 2006; Sullivan & Decker, 2005). Nurses cite various reasons why they do not delegate, including:
• the fear of being resented by coworkers.
• that it is easier to do the work by themselves.
• a desire to be liked by coworkers.
• the belief that they can do it better themselves.
• that they did not learn delegation skills in nursing school.
• the fear of loss of control.
• a lack of confidence in delegation capabilities.
• the fear of criticism by supervisors and coworkers.

Under Delegation

Under delegation occurs when a delegator is unsure of the capability of the delegate or is not confident with his or her own delegation capabilities (Sullivan & Decker, 2005). Marquis and Huston (2006) cite that some nurse managers under delegate because they fear subordinates will resent the tasks being delegated or the delegator does not trust that the delegate will complete the task.

Under delegation also occurs when a nurse believes that he or she is the best person to complete a task (Marquis & Huston, 2006). Although this may be true, others are capable of completing many tasks and the nurse must be free to complete tasks that cannot be delegated. Taking on too many tasks through under delegation can lead to stress, feeling overworked, and job dissatisfaction.

Over Delegation

Over delegation can occur when a delegator is unorganized and has poor time-management skills (Marquis & Huston, 2006). When a delegator delegates too much authority and responsibility, he or she is at risk for potential liability (Sullivan & Decker, 2005). Another reason for over delegation is that the nurse may feel insecure about performing the task competently. When a delegator primarily assigns tasks that are unpleasant and gives the impression that he or she does not want to complete them, the delegate may feel “dumped on” and devalued as an important team member (Cohen, 2004). This is another form of over delegation. Nurses must take care not to over delegate because it can lead to stressed and overworked staff (Marquis & Huston, 2006).

The evidence supports that top down relationships between RNs and UAP may result in decreased job satisfaction and team work (Kalisch & Begeny, 2005). The RN staff need to be cognizant of their communication style so that it reflects an attitude of collaboration and cooperation.

Improper Delegation

Improper delegation occurs because the delegator selects the wrong time, the wrong person, or the wrong reason for task completion (Marquis & Huston, 2006). Frequently, a wrong reason may
be that the nurse reasons that he or she is too busy to take the time to delegate tasks and procedures properly. Delegation of a task that the nurse does not want to do because it is unpleasant or because he or she does not know how to do it is an example of improper delegation. Staff will not follow or respect a nurse who delegates inappropriately.

**SUMMARY**

Registered nurses must have complete understanding of delegation and guidelines for delegation in nursing practice. They must know their job descriptions and understand the guidelines for delegation outlined in their respective state nurse practice acts, the scope of nursing practice, delegation models, and such documents as the NCSBN’s “Five Rights of Delegation.” It is equally important that RNs know the licensing rules for LPNs and LVNs, including their scope of practice and duties and responsibilities identified in healthcare agency position descriptions. The same is true for UAP.

Several tools must be consulted to understand the depth of delegation concepts in practice to prevent unsafe practice scenarios and potential liability for the nurse. Various delegation models have been shared in this chapter, and understanding the concepts within these models can help guide delegation decisions in nurse practice.

Nurses must learn about delegation early in their careers, beginning in nursing school. Theoretical knowledge learned in the didactic classes must be integrated and operationalized in the clinical nursing courses in all practice settings. Optimally, delegation threads will be placed in all didactic and clinical courses across the curriculum. Nurses must be aware of concepts related to delegation and the barriers to effective delegation and know the skill levels and capabilities of their team members.

Reviewing the current research based evidence on delegation is crucial for the nurse. New studies indicate different ways to manage the workforce relative to nurse delegation. Prudent nurses must maintain a current knowledge base relative to delegation strategies and find a forum to share this information with teams of nurses.

**Chapter 3: Prioritization Of Care**

**CHAPTER OBJECTIVE**

After completing this chapter, the learner will be able to prioritize care and use the principles of triage in emergent patient scenarios.

**LEARNING OBJECTIVES**

After reading this chapter, the learner will be able to:

1. Define the concepts of prioritization of care and triage.
2. Describe primary and secondary triage assessment.
3. Describe the five-level triage acuity classification system.
4. Describe child, elder, and domestic or spousal abuse situations.
5. Differentiate between abuse and neglect.

**OVERVIEW**

Nurses make important healthcare decisions every day. On rapid-pace healthcare units, such as emergency departments (EDs) and walk-in clinics, nurses must make complete, quick, and accurate patient physical assessments. Added to this scenario is the fact that nurses must prioritize what to do first and determine which patient has the highest acuity or injury, including threat to life and limb. This is an awesome responsibility!

The purpose of this chapter is to define the concepts of prioritization of care and triage. The three-level, four-level, and five-level triage acuity classification systems will be explained, and use of triage acuity tools will be used to study patient case studies.

Also included in this chapter are the identification and treatment of vulnerable aggregate groups: children, elders, and victims of domestic violence. The concepts of child and elder neglect and child and elder abuse will be differentiated. In all situations involving vulnerable populations, such as those in which abuse and injury are involved, the triage nurse must have keen assessment and history-taking skills. The nurse must set the stage to obtain accurate data under difficult circumstances because the abusing party may accompany the patient to the treatment center.

**Triage and Prioritization of Care**

Prioritization of care is ordering which aspects of care will be done first, with the least important tasks taking place after the priority problems have been managed. Prioritization involves deciding which patient problems require immediate intervention and which ones can wait until a later time because they are not urgent (Silvestri, 2011). In clinical settings, nurses must envision the outcomes of their priority choices, which include the potential problems that can occur if another task is chosen first (LaCharity, Kumagai, & Bartz, 2011). Conversely, nurses must consider future incidents that can occur if a task is not completed, time needed to finish the task, and the impact of nursing decisions on future outcomes. Decision making occurs thoughtfully, but spontaneously, for the experienced nurse. Appropriate prioritizing of tasks, which can appear outwardly to be extensive to the new graduate nurse, is seamless for the experienced nurse.

**Triage Settings**

Walk-in clinics, same day surgical centers, emergency departments, and many physician offices with open walk-in hours have formal triage systems to determine which patient needs to be seen first based on each patient’s current presenting medical condition (LaCharity et al., 2011). The concept of triage implies a sense of urgency. In fact, triage involves ordering tasks and deciding which must be done first based upon the patient’s presenting symptoms. When the nurse prioritizes, a decision is made to determine which problems require immediate attention and which ones can be delayed because they are not as urgent (LaCharity et al., 2011).

Triage involves the initial assessment and sorting by acuity the immediate health problems or injuries of newly arriving patients. Grossman (2003) explained that the word triage is derived from the French word “trier,” which means to sort. Triage principles were practiced in wartimes, when individuals were sorted based on the urgency of their conditions.

People in everyday life have multiple things going on at once and must decide what to do first. The following example demonstrates how a stay-at-home parent must prioritize in a multiple-task situation.

The following things are happening all at once:

- Laundry is on the line and it is starting to rain.
- The baby starts crying.
- The phone starts ringing.
- The water is running in the bathtub and it starts overflowing.
- There is a knock at the door.

These types of events occur in life every day. The stay-at-home parent must decide in what order to attend to daily events such as these.

Nurse managers must prioritize activities as well. The following scenario is an example of multiple tasks that an orthopedic trauma nurse manager must sort out and complete. These activities are everyday events for an orthopedic trauma unit nurse manager:

- The human resources and operating budgets must be completed.
- A patient in an adjacent room has bowel incontinence.
- A code (cardiac arrest) is called on the unit.
- An afternoon shift nurse, who typically covers others’ shifts, calls in ill for that afternoon.
- The education department called earlier in the morning to obtain a roster of nurses on the unit who need to be recertified in basic life support (BLS).

This nurse manager must decide which task to attend to first, which tasks he or she can delegate, and which tasks can wait to be completed at another time. Obviously, the manager should ensure that the cardiac arrest patient in a code situation is attended to first. Caring for a patient who has bowel incontinence and covering the sick call are important to ensure continuity of patient care. Completing bud-

**Resources**

American Association of Critical Care Nurses Standards
http://www.aacn.org/WD/Practice/Content/standards.content?menu=Practice

American Nurses Association and the National Council of State Boards of Nursing Joint Statement on Delegation
https://www.ncsbn.org/Joint_statement.pdf


Kentucky Board of Nursing
http://kbn.ky.gov

National Council of State Boards of Nursing Delegation Documents
https://www.ncsbn.org/316.htm
If the patient demonstrates symptoms of neurologic concerns, a more comprehensive neurological exam is conducted in the secondary survey.

Wagner, Johnson, and Hardin-Pierce (2010) cite a fifth component to the primary survey, E, which addresses exposure and evacuation. The patient should be undressed to determine external causes of the presenting injury (exposure). If the patient’s injury or condition exceeds the capabilities of the receiving hospital, transport to a hospital that can provide more comprehensive care is indicated (evacuation).

The goal of the primary assessment is to identify immediate, life-threatening illnesses or injuries upon arrival in the ED and deliver appropriate interventions through quick action (Perrin, 2009). The patient must be treated quickly and then moved to the secondary assessment process.

**Emergency Medical Treatment and Active Labor Act**

In 1986, Congress passed the Emergency Medical Treatment and Active Labor Act (EMTALA), which requires hospitals to treat all incoming patients, regardless of their ability to pay for treatment, citizenship status, or legal status (American College of Emergency Physicians, 2011). The initial intent of this legislation was to ensure patient access to emergency medical care. It is now considered one of the most comprehensive laws guaranteeing nondiscriminatory access to emergency medical care and, thus, to the healthcare system. Hospitals that must comply with EMTALA (most hospitals) are those that have EDs and accept payment from the Centers for Medicare and Medicaid Services (CMS) under the Medicare program (Finkelman, 2012).

**Secondary Assessment**

Immediately after the primary assessment is completed, a secondary assessment is done to completely assess and evaluate the presenting body system. The mnemonic PQRSTT codes the following secondary assessment criteria: provoking factors, quality of pain, region/radiation, severity of pain, time, and treatment. Table 3-1 describes the secondary assessment of pain and the types of questions a triage nurse may pose.

Research supports that ED triage nurses perform excellent pain assessments (CDC, 2009). A thorough pain assessment is vital for quality clinical care. Assessing pain efficiently and arriving at a correct diagnosis is extremely important in garnering a good patient outcome. Inadequate pain assessment may lead to inadequate treatment and repeat visits to the ED. Pain assessment tools can help the triage nurse interpret the signs and symptoms of pain and discriminate the level of clinical priority. Pain assessment by the triage nurse is an important component of patient care. The skills, experiential background, and credentials of the triage nurse are extremely important in delivery of high-quality care for patients who are admitted with a chief complaint of pain.

If the patient’s presenting complaint is neurological in nature, a complete neurological exam using the Glasgow Coma Scale (GCS) is also completed as part of the secondary survey (Wagner, Johnson, & Hardin-Pierce, 2010). Pupils are reevaluated for size and reactivity to light. Lacerations and fractures to the cranium, cranial edema, and leakage of cerebrospinal fluid are also assessed.

**Bruise Assessment**

Nurses must be aware of what a bruise looks like immediately following injury. Equally important is knowledge of the stages of healing bruises. Table 3-2 reviews the stages of bruise assessment, from the initial injury through the healing phases. The color of the bruise and the age of the bruise are important components of a nursing assessment, especially when abuse is suspected. As the bruise heals, it changes in color from the initial red or reddish blue, to yellowish and, eventually, to a normal tint; then it disappears. The initial questions by the nurse and knowledge of the timing of bruise healing helps the nurse in assessing patients suspected of being abused.

The case study described in Box 3-1 exemplifies why nurses need to be knowledgeable about bruise assessment.

**Assigning Acuity**

Since its development and refinement, the Emergency Severity Index (ESI) has been accepted as best practice for emergency department triage classification. ESI is a five-level triage system, which serves as an estimate of how long an individual patient can wait for examination and treatment. (Agency for Healthcare Research and Quality, 2012) In a 2010 joint statement, the Emergency Nurses Association (ENA) and the American College of Emergency Physicians (ACEP) stated that “Based on expert consensus of currently available evidence, ACEP and ENA support the adoption of a reliable, valid five-level triage scale such as the Emergency Severity Index (ESI).” The most recent version (Version 4) of the Implementation Handbook also addresses the use of ESI for pediatric triage.

The five levels of the ESI range from level 1 (resuscitation needed) to level 5 (non-urgent). (See Figure 3-1). The learner is referred to the AHRQ Website (www.ahrq.gov/research/esi/esi1.htm) for additional information regarding the use of this triage algorithm.

Special consideration must be given to young children and older adults, who may not be able to tolerate injuries or acute illnesses. The intent of the acuity system is to be a guide only – not a definitive tool. A triage nurse must always use expert clinical judgment and adjust the acuity level based on the patient’s current condition.

Knowledge of the five-level acuity system is important for ED triage nurses. Box 3-3 presents a case study for a patient with a chief complaint of abdominal pain. Work through the questions in the case study to enhance your knowledge of the five-level acuity system. Answers can be found in Box 3-4.

Patients who return to the ED may have conditions more severe than their initial assessments supported. Patients also may have been dissatisfied with their previous visits and are seeking a second medical opinion. Each time a patient presents to the ED, a new assessment and evaluation must be completed. Nurses should include cardiac arrest, seizure, anaphylaxis, coma, multiple trauma, and profound shock in the most severe level in any acuity system and ensure that these patients are seen quickly.
TABLE 3-1: SECONDARY ASSESSMENT SURVEY

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Questions That May Be Posed by the Triage Nurse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provoking factors</td>
<td>• What makes the presenting symptom worse? (coughing, deep breathing, pain, or discomfort)</td>
</tr>
<tr>
<td></td>
<td>• What makes it better? (changing position, quiet environment, taking an over-the-counter analgesic)</td>
</tr>
<tr>
<td></td>
<td>• Is any overt trauma present?</td>
</tr>
<tr>
<td></td>
<td>• Is there a history of previous trauma or injury? (arthritic pain related to a sports injury that led to a meniscus repair)</td>
</tr>
<tr>
<td>Quality of pain</td>
<td>• Describe the pain.</td>
</tr>
<tr>
<td></td>
<td>• What does it feel like?</td>
</tr>
<tr>
<td></td>
<td>A pain assessment tool may be helpful in gathering assessment data.</td>
</tr>
<tr>
<td>Region/Radiation</td>
<td>• Where is the pain?</td>
</tr>
<tr>
<td></td>
<td>• What is the origin of the pain?</td>
</tr>
<tr>
<td></td>
<td>• Does the pain radiate to another area of the body?</td>
</tr>
<tr>
<td></td>
<td>• Identify (point to) the exact area of the pain.</td>
</tr>
<tr>
<td>Severity of pain</td>
<td>• Use of pain assessment tools yield objective data.</td>
</tr>
<tr>
<td></td>
<td>Common tools used in the ED are the McGill Pain Questionnaire, Visual Analog Scales, and the Faces, Legs, Activity, Cry, and Consolability (FLACC) Postoperative Pain Tool. A simple 1-to-10 pain-rating scale, with 1 being minimal pain and 10 being most severe pain, allows quick evaluation of the patient’s accounting of his or her pain status.</td>
</tr>
<tr>
<td>Time</td>
<td>• When did the presenting symptom start?</td>
</tr>
<tr>
<td></td>
<td>• How long did the symptom last? (duration)</td>
</tr>
<tr>
<td></td>
<td>• Has the symptom ever occurred before?</td>
</tr>
<tr>
<td></td>
<td>• Describe the circumstance.</td>
</tr>
<tr>
<td>Treatment</td>
<td>• Have you taken a treatment for this symptom in the past? (pharmacologic or nonpharmacologic)</td>
</tr>
<tr>
<td></td>
<td>• Have you taken a medication prior to presenting to the treatment facility? If so, what was the medication?</td>
</tr>
<tr>
<td></td>
<td>• What treatment works best?</td>
</tr>
<tr>
<td></td>
<td>• What treatment has not worked in the past?</td>
</tr>
</tbody>
</table>

TABLE 3-2: BRUISE ASSESSMENT

<table>
<thead>
<tr>
<th>Color of Bruise</th>
<th>Age of Bruise</th>
</tr>
</thead>
<tbody>
<tr>
<td>Red or reddish blue</td>
<td>&lt; 24 hours</td>
</tr>
<tr>
<td>Dark blue or purple</td>
<td>1 to 4 days</td>
</tr>
<tr>
<td>Green or yellow-green</td>
<td>5 to 7 days</td>
</tr>
<tr>
<td>Yellow or brown</td>
<td>7 to 10 days</td>
</tr>
<tr>
<td>Normal tint or disappearance of bruise</td>
<td>1 to 3 weeks</td>
</tr>
</tbody>
</table>


VULNERABLE AGGREGATES

Victims of violence need to be assessed by a skilled triage nurse. Often, victims try to cover the abuse and protect their abusers, which may occur because of several different reasons. The categories of child maltreatment, elder maltreatment, and domestic violence are addressed in this section.

Child Maltreatment

A differentiation must be made between child abuse and child neglect. Child neglect can include many different facets. Supervision neglect is involved when a parent or an adult caregiver leaves a child alone, when the child should be directly supervised (American Humane Association, n.d.; Hussey, Chang, & Kotch, 2006). This may be more readily seen when both parents work full-time. Child neglect represents a persistent inability to meet a child’s needs. Examples include:

- Inadequate supervision – leaving the child alone at home, in a retail store, or in other similar situations.
- Inadequate nutrition – not including a variety of nutritious foods or lacking appropriate amounts of food in a child’s diet.
- Inadequate clothing – not having warm clothes in the winter or appropriate shoes and boots for inclement weather situations.

The nurse must assess whether the neglect provides for provision of adequate food, clothing, and shelter is a volitional act on the parent’s part or whether the parent or adult caregiver lacks financial resources (American Humane Association, n.d.). The nurse must also determine whether the parent has the intellect and emotional well-being to safely and adequately care for the child. Assessment of child neglect is subjective, so it is imperative that the ED triage nurse have expert clinical judgment.

Child Abuse

Child abuse is maltreatment that involves physical assault, physical neglect, sexual abuse, or emotional (including verbal) abuse (American Humane Association, n.d.). The most vulnerable cohort is children younger than 5 years of age. They have the largest fatality rate among children because of their size, developmental stage, and inability to provide self-care. The ED nurse can refer suspected child abuse situations to child protective services and should have all contact information clearly documented in a central area for quick access.

Physical Assault

Physical assault includes being slapped, hit, kicked, or otherwise physically injured. Bruises are the most common presenting symptom, followed by fractures and head injuries. Physicians must suspect abuse in cases involving spiral fractures because these injuries are commonly caused by twisting. Burn injuries that are circumferential may be a result of dipping the child’s hands or feet in scalding water.

The nurse should suspect child abuse if:

- the child avoids eye contact with the parent or adult caregiver.
- the child presents with repeated injuries.
- the child presents with unexplained bruises (in various healing stages) or injuries.
- inconsistencies appear in the parent’s or adult caregiver’s account of the incident.
- wounds take on certain shapes, such as a cigarette burn or a curling iron burn.
An elderly woman comes into the ED with her son. Her chief complaint is that her left arm hurts after a fall. She says, “Clumsy me, I fell 2 weeks ago and this arm still hurts.” Her son remains in the exam room with her. The patient lives in her son’s home. The ED nurse must gain more assessment data and asks the son to leave the room during the exam. The orthopedic surgeon orders an X-ray of the left arm, which confirms that the patient has a left humerus spiral fracture. At the initial assessment, the patient rates her pain as a 9 on a 10-point scale, with 1 representing very low pain and 10 representing very intense pain. The patient exhibits facial grimacing, is tearful upon the slightest movement, and guards the left arm, despite the fact that it has been immobilized. There is bruising, which is mostly bluish with some red aspects. Her son is requesting to re-enter the exam room.

Discussion Questions
1. What could the triage ED nurse do to obtain more initial assessment data, given that the patient’s son was in the exam room?
2. What type of information does an accurate bruise assessment tell the ED nurse?
3. What type of injury does the arm fracture suggest?
4. Do the ED nurse and the orthopedic surgeon have enough assessment data to call in adult protective services if the patient is persistent in saying that this intervention is not necessary? Why might she be saying this?
5. What is the difference between physical abuse and physical neglect?

See Box 3-2 for answers to these questions.

BOX 3-2: ANSWERS TO TRIAGE CASE STUDY – KNOWING BRUISE ASSESSMENT

1. Gaining objective and accurate assessment data is crucial for the care of this patient. When abuse is suspected, it is important to interview the patient alone. In addition to asking the son to leave the room, the ED triage nurse could accompany the elderly patient to X-ray, if her workload allows, and ask further questions without the son being present.
2. The bruise is bluish red, which means it is a new bruise, less than 24-hours old.
3. Because the injury is a spiral fracture twisting injury, the ED triage nurse should suspect potential abuse in the home.
4. Yes. An astute ED triage nurse would look at old medical records to see whether the patient has sustained similar injuries in the past. If yes, this may point to a pattern of abuse. The elder woman may want to cover for the perpetrator because she would rather live in her son’s home than in a nursing home.
5. Physical abuse is intentional harm toward another person, such as hitting, kicking, biting, or using unnecessary physical restraint. Physical neglect involves inadequate food, shelter, and clothing for environmental conditions.

• the child appears nervous or frightened.

Although not conclusive, the nurse should be alert for other signs if the parent or adult caregiver refuses to allow the child to be alone with the nurse or other healthcare provider. This may represent caring concern or it may represent an attempt to prevent the child from being asked questions about the circumstances of the injury without an adult present.

The triage nurse must ask open-ended questions to obtain accurate assessment data, such as:

• “Tell me again, how did this injury occur?”
• “What time of day did you say this injury happened?”
• “Who did you say was present when this injury occurred?”

Asking broad, open-ended questions provides more information than simple yes-or-no questions. Repeating questions and stating, “Tell me more,” may yield more information. If an adult changes his or her story, that is information in itself. All of this information must be documented in the medical record.

Shaken Baby Syndrome
Another form of abuse seen in infants is shaken baby syndrome. This form of child abuse involves a collection of signs and symptoms that result from violent shaking of an infant or toddler, which can result in head trauma (National Center on Shaken Baby Syndrome, n.d.). Each year in the United States, treatment is sought for approximately 1,300 children who are shaken, and approximately 20% die from their injuries (National Center on Shaken Baby Syndrome, n.d.).

In shaken baby syndrome, tissue damage and broken blood vessels within the skull cavity can cause permanent neurological damage. Nurses should note that infants presenting with compromised breathing, extreme irritability, seizure activity, limp or rigid posturing, and a decreased level of consciousness are exhibiting immediate consequences of being shaken too hard. Survivors can have lifelong disability complications that include learning disabilities, physical disabilities, visual disturbances or blindness (excessive retinal bleed), hearing impairments, speech disabilities, behavior disorders, and cognitive impairment.

Bullying
Bullying has been identified as a growing issue in our country and a serious health problem (American Humane Association, n.d.; CDC, 2009). It is a form of abuse inflicted by one child upon another child. This behavior is defined as an imbalance of power and an intention to harm with repeated occurrences. The categories of bullying include verbal (name calling), emotional intimidation (rumor spreading), physical (hitting, hair pulling), relational (excluding peers from social events), and sexual (unwanted touch). New technology has ushered in the newest forms of bullying through multiple social media outlets, cyberbullying (harassment on a Website or over e-mail) and sending emotionally damaging text messages about another person.

The American Humane Association, an organization dedicated to the protection of children, cites bullying as a form of emotional abuse. Parents should not view bullying as a rite of passage because repeated bullying can lead to health problems, such as headache and depression.

If a child presents to the ED and the nurse suspects bullying, he or she should ask broad, open-ended questions. Sample questions are, “Is there anything at school that makes you afraid?” and “Has a person at school made you sad?” Based on the responses, the nurse can probe further to gain as much assessment information as possible. Interventions should be implemented if bullying is suspected, including informing unaware parents that a child is being bullied at school, so a teacher or school administrator can be informed. Schools have policies related to inappropriate behaviors such as bullying (American Academy of Child and Adolescent Psychiatry, 2011).

Emotional Abuse
The perpetrator of emotional abuse attempts to lower a child’s self-esteem by making comments either privately or openly in a group that will embarrass the child (American Humane Association, n.d.). Ongoing emotional abuse of a child is characterized by actions that interfere with cognition, emotional, social, and psychological development. Forms of emotional abuse include:

• ignoring a child, silent treatment
• rejecting actions – refusing to touch or hug, verbal ridicule
• isolating child from others
• exploiting a child – teaching a child how to shoplift
• verbal assaults
• terrorizing a child – creating a climate of fear; for example, threatening to withhold food for a pet if the child does not clean his or her room.

The triage nurse should look for the following signs when completing an assessment, which may indicate that a child is a victim of emotional abuse:

• challenging behaviors
• sleep disturbances
• bouts of anger
• developmental delays
• flat, blunted affect
• expression of intense attempts to please parent or adult caregiver
• regressive behaviors (i.e., rocking in an older child).

A parent’s constant attempt to berate a child can impair the child’s emotional progression (American Humane Association, n.d.). Emotional abuse can occur with other forms of child abuse when the abuser uses words before, during, or after abuse that aim to hurt, coerce, frighten, or diminish the child’s self-esteem and self-worth. Social agencies such as child
Leadership and Management for Every Nurse

**protective services** can be called into a healthcare agency if a caregiver or parent is suspected of abuse.

### Physical Neglect

Physical neglect is the most common form of child abuse (National Institutes of Health, 2011). It involves more than child neglect that is the result of a parent not being able to afford food or warm clothing or not having the intellect to better determine the physical needs of the child. Physical neglect occurs, for example, when a parent makes a conscious choice to buy cigarettes or alcohol instead of food (Hussey et al., 2006). Another example would be not keeping a child clean through bathing. Poor oral care and inadequate hygiene are other forms of physical neglect.

### Sexual Abuse

Research supports that by the time a child enters the sixth grade, there is a 1 in 25 chance that abuse has occurred (Hussey et al., 2006). Sexual abuse is one of the most common causes of pelvic pain in prepubertal children (American Humane Association, n.d.).

### Elder Maltreatment

Like child abuse, elder abuse is a growing national problem. A negative stigma is associated with all categories of abuse. Just like child abuse, elder abuse can involve physical neglect, physical abuse, psychological or emotional abuse, and sexual abuse. Elder abuse also encompasses financial abuse (Harris, 2006). Elders are commonly vulnerable to abuse because of illness, dependency, or other factors.

Elders may feel ashamed for reporting abuse for several different reasons (Harris, 2006; University

---

**FIGURE 3-1: ESI TRIAGE ALGORITHM**

<table>
<thead>
<tr>
<th>A. Immediate life-saving intervention required:</th>
<th>B. High risk situation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Airway, emergency medications, or other hemodynamic interventions (IV, supplemental O₂, monitor, ECG, or labs DO NOT count); and/or any of the following clinical conditions: intubated, apneic, pulseless, severe respiratory distress, SPO₂&lt;90, acute mental status changes, or unresponsive.</td>
<td>is a patient you would put in your last open bed.</td>
</tr>
</tbody>
</table>

| C. Resources: Count the number of different types of resources, not the individual tests or X-rays (examples: CBC, electrolytes, and coagulation tests equals one resource; CBC plus chest X-ray equals two resources) (see Table below, left). |

| D. Danger Zone Vital Signs. Consider up-triage to ESI 2 if any vital sign criterion is exceeded. |

<table>
<thead>
<tr>
<th><strong>Pediatric Fever Considerations:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. 1 to 28 days of age: assign at least ESI 2 if temp &gt;38.0° C (100.4° F)</td>
</tr>
<tr>
<td>2. 1-3 months of age: consider assigning ESI 2 if temp &gt;38.0° C (100.4° F)</td>
</tr>
<tr>
<td>3. 3 months to 3 years of age: consider assigning ESI 3 if: temp &gt;39.0° C (102.2° F), or incomplete immunizations, or no obvious source of fever.</td>
</tr>
</tbody>
</table>

(Refer to teaching materials for further clarification)

---

**TABLE 3-1: ESI TRIAGE ALGORITHM**

<table>
<thead>
<tr>
<th>Resources</th>
<th>Not Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labs (blood, urine)</td>
<td>History &amp; physical (including pelvic)</td>
</tr>
<tr>
<td>ECG, X-rays</td>
<td>Point-of-care testing</td>
</tr>
<tr>
<td>CT, MRI, ultrasound, angiography</td>
<td>Saline or heplock</td>
</tr>
<tr>
<td>IV fluids (hydration)</td>
<td>PO medications</td>
</tr>
<tr>
<td>IV, IM, or nebulized medications</td>
<td>Tetanus immunization</td>
</tr>
<tr>
<td>Specialty consultation</td>
<td>Prescription refills</td>
</tr>
<tr>
<td>Simple procedure = 1 (laceration repair, Foley catheter)</td>
<td>Simple wound care (dressings, recheck)</td>
</tr>
<tr>
<td>Complex procedure = 2 (conscious sedation)</td>
<td>Crutches, splints, slings</td>
</tr>
</tbody>
</table>

**BOX 3-3: CASE STUDY – FIVE-LEVEL ACUITY SYSTEM**

A 46-year-old athletic trainer presents to the ED complaining of burning abdominal pain. She points to her right upper abdominal area with one finger and states that the pain presented itself within an hour and a half after she ate a triple-dip ice cream cone for lunch. The pain is present whether she is standing, sitting, or lying down. She denies radiation of pain, and she is mildly diaphoretic. Assessment data are as follows:

- Past medical history is negative.
- Medications: Maalox as needed.
- Allergies: No known allergies.
- Respiratory rate 16 and regular

1. What is this patient’s acuity level, based on the five-level acuity system?
2. The patient asks the triage nurse, “What do you think is going on?” What should the nurse’s response be?

*See Box 3-4 for answers to these questions.*

**BOX 3-4: ANSWERS TO CASE STUDY – FIVE-LEVEL ACUITY SYSTEM**

1. Acute. ESI Level 2; possibly, Level 3 if the pain has subsided somewhat. The patient has a slightly elevated apical heart rate compared to the baseline apical pulse within her medical record from a previous hospital visit. She is mildly diaphoretic and the cause of her pain has not been determined. The ED physician or nurse practitioner will order labs and do a medical work-up, which will include an ultrasound of the right upper quadrant.

2. The ED triage nurse should never guess at a medical diagnosis. He or she should reassure the patient that the appropriate tests will be ordered to help determine the cause of her pain. Even though the triage nurse has seen other patients present with the same symptoms and thinks it may be cholecystitis, the nurse should not voice this opinion. Nurses at triage do not have all of the information needed to suggest any particular diagnosis to the patient.

**TABLE 3-3: RECOMMENDED QUALIFICATIONS AND PERSONAL ATTRIBUTES OF THE ED TRIAGE NURSE**

| License                  | • Registered nurse (RN)  
|                         | • Advanced Practice Registered Nurse (APRN) in some emergency departments  
| Courses                 | • Trauma Nursing Core Course (TNCC)  
|                         | • Advanced trauma nursing  
|                         | • Emergency Nursing Pediatric Course (ENPC)  
|                         | • Triage  
|                         | • Emergency communications RN  
| Materials review        | • Hospital ED competency-based orientation program  
|                         | • ED policies and procedures  
|                         | • Trauma nurse core curriculum  
| Certification           | • Basic life support (BLS)  
|                         | • Advanced cardiac life support (ACLS)  
|                         | • Pediatric advanced life support (PALS)  
|                         | • Certified emergency nursing (CEN)  
| Skills                  | • Telephone triage  
|                         | • Excellent assessment and nursing process skills  
|                         | • Ease with delegation and supervision  
|                         | • Working knowledge of local and regional emergency services (helicopter, ambulance, fire, police)  
| Experience              | • Minimum 6 months ED  
| Personal attributes     | • Excellent communication, decision-making, and interpersonal skills that inspire collaboration and cooperation  
|                         | • Flexibility to meet rapidly changing needs in emergent situations  
|                         | • Ability to anticipate emergent care needs for individual clients  
|                         | • Resources to handle communication issues with clients who speak English as a second language  
|                         | • Skills to manage highly charged emotive situations  
|                         | • Awareness and sensitivity to sensory impairments (sight and hearing)  
|                         | • Knowledge regarding intoxication and overdose from ethanol or drugs  
|                         | • Knowledge of the emergency department and its capacity and staff capabilities of Delaware and National Center on Elder Abuse, 2012). Reluctance to report elder abuse is particularly challenging when the abuser is a family member. Shame associated with abuse within a family is difficult for all family members, especially the abused elder. If elder abuse (or any type of domestic violence episode) is suspected, adult protective services should be contacted. Contact information should be readily available to healthcare providers.

Most elder abuse occurs in the home, rather than in healthcare institutions. Aging parents may live with an adult child who is not equipped to care for aged parents. This may be due to the fact that they work full-time, are unaccustomed to having someone live in the home that needs assistance, and were not aware of the time commitment required to care for aging parents. Older men are more likely to report financial abuse or physical neglect, whereas older women are more likely to report physical and emotional abuse.

**Physical Neglect**

Just like child neglect, elder neglect occurs when a vulnerable elder cannot complete self-care activities and goes without a bath, food, warm clothing, or appropriate shelter (drafts or leaking roofs not fixed). An example of institutional neglect is when a caregiver delivers a meal and leaves the room knowing that the patient cannot cut his own food or feed himself. Harris (2006) notes that a well-dressed caregiver and a poorly dressed patient, especially in terms of proper dress for weather conditions, is a “red flag” for elder neglect. Examples of elder neglect include:

- withholding or failing to deliver necessary care
- malnutrition
- unsanitary living conditions
- failure to toilet (leading to soiled linens)
- withholding food and fluids.

Various forms of neglect can occur in poorly staffed nursing homes and long-term care facilities. Frequently cited areas of litigation include excessive patient falls, some of which result in injury. Pressure sores from lack of turning bedridden patients or lack of mobility can cause skin breakdown. Lack of patient monitoring may result in dehydration, weight loss, and serious infections (Mayo Clinic Staff, 2011). These forms of neglect are avoidable and support the belief that additional staffing, which includes paid sitters, could avert some of these conditions.

**Physical Abuse**

An astute triage nurse must be aware of the signs and symptoms of elder abuse and question why they are present in a patient (Harris, 2006; University of Delaware and National Center on Elder Abuse, 2012). A few examples are:

- physical restriction of movement
- misuse of drugs, including sedatives, anti-anxiety medications, and narcotics (also includes overdose of medications [beyond what the physician has ordered])
- burns
- fractures and healed fractures on X-ray
- multiple bruises in various phases of healing.
Financial Abuse

Signs of elder physical abuse or neglect are usually visible; however, they often are accompanied by financial abuse that is not so readily apparent. Nurse managers and leaders as well as staff nurses should be alert to this possibility and explore when appropriate. All forms of elder abuse are ugly; however, the greed seen in financial abuse is especially repugnant. Misappropriation of an elder’s funds, misuse of funds, and coercion into signing checks are forms of financial abuse (Harris, 2006; University of Delaware and National Center on Elder Abuse, 2012). Other examples of financial abuse of elders include:

- theft
- missing (selling) valuables
- sudden changes in the elder’s will
- gaining authority (consent) over the elder’s finances through devious or unethical means.

The nurse should question potential financial abuse when she hears a patient state, “I have to ask my daughter for money to pay the electric bill.” Another red flag could be, “I cannot seem to find my grandmother’s diamond brooch.”

Psychological and Emotional Abuse

The University of Delaware and National Center on Elder Abuse (2012) and Harris (2006) cite the following as common signs and symptoms of emotional abuse in elders:

- anxiety in the presence of the caregiver
- generalized agitation, nervousness
- regressive behavior, such as rocking or sucking
- verbal abuse toward the elder (i.e., “Mom, why are you so clumsy?”)
- name calling
- dismissive behavior toward the elder, such as ignoring the person or giving the “cold shoulder”
- intentional provocation of fear or distress
- harassment
- indications of sexual abuse.

Sexual Abuse in Elders

Vulnerable elders are also at risk for sexual exploitation (University of Delaware and National Center on Elder Abuse, 2012). Other forms of sexual abuse that may be suspected are forced voyeurism, inappropriate touching, or any sexual activity for which the elder has not given consent. Signs and symptoms of sexual abuse for which the triage nurse should assess include:

- vaginal or anal tears
- bruising in the genital area
- abrasions
- patient complaint of pelvic pain
- bleeding
- presence of a sexually transmitted disease.

Domestic Violence

Smith and Segal (2012) explain that domestic violence and abuse, also known as spousal abuse and violence, can happen to anyone and that the issue is often ignored, excused, or denied. This is especially true if the abuse is psychological, rather than physical. The abuser’s goal is to gain control over the spouse or partner.

According to the American College of Emergency Physicians, or ACEP (2013), women seeking care in the ED are often the victims of domestic violence. The most common form of domestic violence is spousal or partner abuse. The male partner commonly uses patterns of assault and intimidating actions to assert power and control over his partner. In many cases, the woman is on an allowance, has to ask permission to drive the car, and is told what to buy at the grocery store. Violence and maltreatment can take many forms, including sexual abuse, emotional abuse, financial exploitation, and intimidation. The ACEP recommends that suspected victims of spousal abuse be assessed for intimate partner violence (IPV). They further share that more appropriate evaluation for IPV is needed in health settings to help treat victims.

Up to 12% of males are victims of domestic violence; however, they tend not to report the abuse out of embarrassment. Men are more commonly victims of verbal assault, whereas women are victims of physical abuse in domestic disturbances. The results of physical abuse seen in healthcare facilities may include:

- fractures
- soft-tissue trauma
- arthritic neck pain
- pelvic pain
- migraine headaches
- depression
- suicidal ideation, attempted suicide, or suicide
- death.

Often, women do not report their abusive spouses because of fear of financial abandonment and threat of the male to take the children. When ED care providers offer suggestions for shelter or a safety plan, a concern of some women is that their husbands will report that they abandoned the children and later use that claim in a court of law to attempt to gain child custody.

Documentation and Resources

Triage nurses, ED personnel, and physicians are in excellent positions to advocate for victims of abuse. They can provide helpful Websites, refer patients to counselors, and provide written materials and hotline numbers.

All abuse must be documented, including clinical pictures of the abuse, which should be kept in the patient’s medical record. Pictures taken in a healthcare setting are frequently done by law enforcement officials. Permission for these photographs usually is not necessary in these situations because the photographers serve as documentation in a court of law. Emergency Departments across the country have special forms to document child, elder, and domestic violence abuse. Rules for reporting the abuse vary from state to state, and the triage nurse must be aware of the guidelines for reporting abuse in his or her state. Emergency care providers are mandated to report child abuse and elder abuse. The obligation to report domestic or spousal abuse varies from state to state. The most prevalent opinion among experts is that the adult has a right to make the determination of whether and when to report the violence.

SUMMARY

Nurses educated in triage principles must advocate for the patients they serve. This is especially important for vulnerable aggregate cohorts in this society. Nurses and physicians are commonly the voices for these vulnerable populations. Prioritization and triage acuity levels provide a guide for decision making but do not replace the expert clinical judgment that triage nurses should possess. Although triage in the ED has been used as an example of priority setting in this chapter, it should be recognized that priority setting takes place in ALL settings where nurses practice. A key aspect of priority setting is an accurate assessment of patient needs and the appropriate interventions necessary to best manage patient conditions.

Abuse must be reported according to each state’s reporting rules. Nurses should know their states’ law enforcement rules and should have contact information for child protective services and adult protective services available in the ED. Often, nurses and physicians are the only people who can help stop the cycle of violence.

Answer the self-assessment questions for Chapter 3 at the end of the course.

RESOURCES

Childhelp
800-4-A-CHILD
http://www.childhelp.org

Emergency Nurses Association
http://www.ena.org

Futures Without Violence
http://www.endabuse.org

MedlinePlus: Elder Abuse

National Center on Shaken Baby Syndrome
http://www.dontshake.com

National Domestic Violence Hotline
800-799-7233 (toll free)
800-787-3224 (for the hearing impaired; toll free)
http://www.ndvh.org

Nursing Network on Violence Against Women, International
http://www.nnvawi.org

Rape, Abuse, & Incest National Network
National Sexual Assault Hotline
800-656-4673 (toll free)
http://www.rainn.org

Triage First, Inc.
http://www.triagefirst.com

United Way – AIRS
2-1-1: Get Connected. Get Answers
http://211tus.org

U.S. Department of Health & Human Services, Administration for Children & Families
Child Abuse and Neglect
http://www.acf.hhs.gov/blog/category/child-abuse-neglect

U.S. Department of Health & Human Services, Health Resources and Services Administration
Bullying Prevention Campaign

U.S. Department of Health and Human Services, Office on Women’s Health Violence Against Women
800-994-9662 (toll free)
http://www.womenshealth.gov/violence-against-women
CHAPTER 4: DECISION MAKING

CHAPTER OBJECTIVE

After completing this chapter, the learner will be able to describe problem-solving processes and quantitative tools used to make decisions.

LEARNING OBJECTIVES

After reading this chapter, the learner will be able to:
1. Define the components of decision making.
2. Apply quantitative tools of decision making to formulate objective decisions.
3. Compare the steps in the problem-solving process to decision making.
4. Evaluate strengths of and limitations to effective decision making.

OVERVIEW

Nurses make decisions and resolve problems on a daily basis in practice. Decision making and problem solving are not the same, but the processes for decision making and problem solving are parallel. Both of these concepts require sound critical thinking competence. Decision making is a behavior that involves critical, reflective, and intuitive thinking (DeLaune & Ladner, 2011). Decision making includes selecting and implementing interventions or actions to achieve a desired goal; however it may not involve an immediate problem. Problem solving is specific and begins when a dilemma is identified and ends with a solution to the specific situation.

Throughout this chapter, the learner will learn different strategies for resolving problems and different quantitative tools to assist with objective decision making. Examples of how these tools are used in practice will be demonstrated. Maintaining an open mind on issues and their resolution can lead to creative ways to resolve issues and problems.

Healthcare Influences

Health care has seen many changes in a short period of time. While improvements in health care have decreased age-related mortality, they have also increased the number of persons living with chronic diseases and the complications that accompany them. The increased need for care demands efficiency. Fueled by competition in the healthcare market, patients are typically discharged “quicker and sicker” than in years past, resulting in an overall higher patient acuity level in both acute care and long-term care facilities. Uncertainty and complexity are now considered normal in health care; therefore, nurse managers and leaders must understand that decision making involves taking risks and making bold moves (Keynes, 2008). Managers are challenged to make good decisions in a timely manner in order to meet these demands.

DECISION MAKING

Decision making is a focused and goal-directed attempt to use a logical process to choose among different options. Decision making that is used to manage issues is neither inherently good nor bad. Decision making involves several alternatives for consideration. For example, a department manager wants the nursing staff to be more responsible.

The options for the endeavor include having all staff nurses serve on department committees, complete self-evaluations, complete peer evaluations, and determine the weekend call schedule.

The professional nurse needs to possess a highly complex set of skills, using higher levels of thinking, to deliver needed care in all clinical settings. Inadequate recognition of evolving medical emergencies, or failure to make a decision and take action, may lead to poor patient outcomes (del Bueno, 2005). Clinical decision making combines knowledge, information management systems, and practical experiences regarding patient care (DeNisco & Barker, 2013). Characteristics associated with effective decision making include being assertive, knowledgeable, observant, resourceful, intuitive, and creative (Toofany, 2008).

Decision making involves two basic phases (Junnola, Eriksson, Salantera, & Lauri, 2002). The first phase involves observation, data collection, and data processing that lead to problem identification. The second phase is a management phase that involves planning and implementation of interventions. Healthcare personnel make decisions daily by processing information in this way. Decision making is an essential component of the nursing role, and learning a structured approach to decision making helps organize the process. A competent decision maker:

- lists all possible solutions
- has a back-up plan
- involves other people in the decision-making process
- employs excellent critical thinking skills
- is open minded (does not have preconceived solutions)
- uses excellent communication skills, especially listening.

Organized systems for decision making are the best ways to promote quality decisions; however, these systems can be time consuming. Table 4-1 delineates the process for traditional problem solving (reviewed in the next section), the nursing process, and the management decision-making process; three systems that are closely related.

Critical Thinking

Nurses working at the bedside must balance time constraints associated with the demands of higher acuity patients and increased workloads. Critical thinking and sound decision-making and problem-solving skills are necessary for all nurses and nursing leaders (Thomas & Herrin, 2008). This extends to the delivery of effective patient care from the organizational system view to the bedside patient care arena (Grossman, 2007). Critical, reflective, and intuitive thinking are all considered an integral part of decision making.

Critical thinking is a complex cognitive process that involves the nurse’s knowledge, attitudes, and skill. It includes gathering data as well as examining and questioning the validity of what is seen or heard in order to create new ideas. Critical thinking is a set of cognitive skills including “interpretation, analysis, evaluation, inference, explanation, and self-regulation” (Facione, 2013, p. 1). When applied to nursing, the additional attributes of creativity, intuition, and ability to transform knowledge enhance the critical-thinking abilities of the nurse (Rubenfeld & Scheffer, 2006). Nurses who are critical thinkers are creative in their thinking and anticipate the consequences of their thinking. Critical thinking encompasses what to do, or how to do something, and also why it is done.

Reflective thinking is a form of evaluation in which the nurse considers a situation and the actions taken to determine if a better (or more efficient) intervention or method might be available. Although all nurses should practice reflective thinking, nurses especially benefit from increased confidence by regularly reflecting on the care they provide and making adjustments based on their reflection.

Another influence on decision-making is intuitive thinking or “gut feeling.” Although the concept of intuitive thinking is rather abstract, it is considered the result of unconscious analysis of situations, combined with previous experience, to provide insight into a situation (Dossey & Keegan, 2009). Alfaro-LeFevre (2009) contends that a “gut feeling” is higher level, or critical thinking, that combines evidence and experience to make expert decisions.

DECISION-MAKING TOOLS

Several decision-making tools can be employed to make objective, quantifiable decisions. When making difficult decisions, such as those required in situations involving ethics, a decision-making tool can help those involved make a choice under the most difficult circumstances. The use of this type of decision-making tool will be further explained in chapter 13. Tools guide the decision-making process; however, people make the final decisions (Finkelman, 2012). Utilizing various tools is beneficial for all, but they may be especially useful for the novice nurse or nurse leader. Toofany (2008) recommends introducing concept maps to orientees as a way to define and clarify nursing priorities. A concept map is an interactive, visual learning tool that encourages thinking and the ability to see how parts represent the whole picture. For example, if the nurse manager of

<table>
<thead>
<tr>
<th>TABLE 4-1: DECISION-MAKING PROCESSES COMPARED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem-Solving Process</td>
</tr>
<tr>
<td>Define problem</td>
</tr>
<tr>
<td>Collect data</td>
</tr>
<tr>
<td>Analyze data</td>
</tr>
<tr>
<td>Develop interventions</td>
</tr>
<tr>
<td>Select intervention</td>
</tr>
<tr>
<td>Implement</td>
</tr>
<tr>
<td>Evaluate</td>
</tr>
</tbody>
</table>
a neurology unit was thinking of developing a new unit-based model for care delivery, he or she would think of all aspects related to that model: neurology nursing practice, case mix variety on the unit, neurology nursing standards of practice, nurse led in-service education, specialty neurology interests such as multiple sclerosis, and the experience of nurses on the unit. By looking at all aspects of a situation, the nurse manager can better discuss a new unit plan.

Each decision-making tool has limitations, and the nurse must decide which tool is best for each circumstance in which a decision is needed.

Decision Tree
A decision tree is a schematic representation that helps organize all key elements in a situation to help make an informed decision (Finkelman, 2012). All possible events are placed on the tree, and the decision-maker refines events until a decision point is reached. See Figure 4-1 for an example of a decision tree illustrating a payoff table that addresses the demand for procedures and the use of overtime. This method of critical thinking is one of analyzing and involves breaking down each variable in order to better understand the ramifications of a decision. It is a repeated exercise of listing options, possible events, and outcomes that results in finally arriving at a decision point.

Decision Grid
A decision grid, or matrix, assists the decision maker to compare several items, based on the same criteria. In Table 4-2, orthopedic nurses and physical therapists are using a decision grid to help them make a purchase recommendation for a continuous passive motion machine. The grid provides a visual tool to rate or quantify multiple variables. By analyzing the multiple factors and assigning a numeric score based on importance, a composite score helps clarify where the priority should rest.

Numerical Scoring
Numerical scoring is an easy tool to use, requires little time, facilitates a quick decision, and allows a decision maker to simultaneously view all alternatives. With this tool, each possible strategy for resolving a problem or situation is assigned a number based on criteria. For example, a hospital wants to purchase a new staffing tool for the nursing units. The criteria for selection of a staffing tool are:
- time for implementation
- cost
- staff knowledge of the tool
- organization’s acceptance of the tool
- impact on employee turnover.

With the use of numerical scoring, the decision on which staffing tool to purchase would be based on the highest numerical score based on these criteria.

Payoff Tables
Payoff tables are an especially popular tool among administrators. They are used to make decisions based solely on fiscal impact (Yoder-Wise, 2011). For example, a nurse executive is responsible for approving funding for the costs associated with having a staff development session on the use of new implantable pumps for long-term antibiotic use. The nurse executive stipulates that the event cannot incur a loss; it must at least break even. Therefore, the director of the education department determines the costs for the staff development session.

The cost per individual to attend the event is set at $50.00, and the total cost for the event is $2,000. See Table 4-3 to review the costs associated with offering a staff development session. Based upon the quantitative data in the payoff table, a decision can be made whether to offer the session.

Critical Thinking Exercise
How many nurses must sign up to meet the nurse executive’s criteria for a budgetary break-even point? How many nurses would signify a profit? A loss? What creative strategies can the education director employ to transfer funds from the event to the education department’s budget?

FIGURE 4-1: DECISION TREE – DEMAND FOR PROCEDURES AND OVERTIME

This illustration depicts a decision tree in which a same-day surgery department is trying to determine the best ways to resolve the issues of meeting the demand for procedures to be done and of paying straight time (would need to decrease the number of procedures) versus overtime (pay staff for services) to complete more procedures in the department.

Possible Events
- Increased demand for procedures
- Decreased demand for procedures
- Increased demand for staff
- Decreased demand for staff

Alternative Actions
- Hire regular staff
- Pay overtime and on-call wages

Decision point (last event to occur)

Response
Calculating the budgetary break-even point is simple: $2,000.00 divided by $50.00/attendee = 40. Therefore, 40 nurses must enroll in the staff development session for a budgetary break-even point to occur. A profit would occur if more than 40 nurses enrolled in the staff development session. A loss would occur if fewer than 40 nurses enrolled in the staff development session.

Follow Up
The education director wants to increase the money available to her department in the budget. She secures a donation of an implantable infusion pump and the associated supplies from a company representative and asks if the money saved can be placed in her department’s operating budget. The nurse executive, recognizing and appreciating the resourcefulness of the education director, grants the request.

SWOT Analysis
A SWOT (strengths, weaknesses, opportunities, threats) analysis is another tool used by groups and individuals to guide decision making. This tool is frequently used by marketing departments when a hospital is thinking about adding a major service such as a same day surgical center. Strengths and weaknesses are internal to the hospital, hospice, long-term care agency, or other healthcare agency; that is, they occur within the organization (Yoder-Wise, 2011). Conversely, opportunities and threats are considered external factors, meaning that they occur outside of the organization (Pearce, 2007). Therefore, the SWOT tool is used to critically review:
- Strengths: expertise, resources, and advantages of an individual or organization
- Weaknesses: areas in which an individual or organization do not excel, areas of vulnerability, resource insufficiency
- Opportunities: positive opportunities available to an individual or organization
- Threats: things that can harm the individual or organization, environmental (community) changes.

Box 4-1 presents a case study involving a nurse with a career goal of becoming a chief nursing officer. The case study reviews her background and outlines the strengths, weaknesses, opportunities, and threats relative to this goal. See Figure 4-2 to review information for the SWOT analysis for the nurse in the case study. Based upon information in the SWOT analysis, an analysis of the findings is drawn (see Box 4-2). Sometimes, if a person has a great strength, it can compensate for his or her weaknesses. In this case, Jane is a very bright person who graduated with honors and has a very bright future in the profession.

PROBLEM-SOLVING
Problems can be resolved in any of several different ways. Quality and Safety Education for Nurses (2011) states a goal to reduce the risk of harm to patients and providers through system effectiveness and individual performance. After a problem is identified, there may not be a need to find a quick solution (Finkelman, 2012). For example, an agency policy stipulates that nurses must rotate annual holidays and work them every other year; however, having holidays off every other year may create a problem if massive resignations occur. To
Leadership and Management for Every Nurse

Figure 4-2: Complete SWOT Analysis for J. Williams

In this sample decision grid, the nurses on an orthopedic surgical unit and the physical therapists are evaluating which continuous passive motion (CPM) machine to purchase based on certain criteria. This grid allows different products to be compared, persons evaluating the products to see which CPM machines others thought were best, and which CPM machine the group collectively thought would be the best purchase.

In the rating used, 1 is least favorable and 10 is most favorable.

<table>
<thead>
<tr>
<th>Alternatives</th>
<th>Weight of CPM</th>
<th>Cost</th>
<th>Availability</th>
<th>Flexion/Extension</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1 CPM machine</td>
<td>2</td>
<td>9</td>
<td>9</td>
<td>5</td>
<td>25</td>
</tr>
<tr>
<td>#2 CPM machine</td>
<td>8</td>
<td>3</td>
<td>7</td>
<td>8</td>
<td>26</td>
</tr>
<tr>
<td>#3 CPM machine</td>
<td>10</td>
<td>1</td>
<td>1</td>
<td>10</td>
<td>22</td>
</tr>
</tbody>
</table>

TABLE 4-3: Payoff Table – Staff Development Event

<table>
<thead>
<tr>
<th>Supplies</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implantable infusion pump</td>
<td>$1,000</td>
</tr>
<tr>
<td>Supplies associated with use of the infusion pump (tubing, flush solution, gloves)</td>
<td>$100.00</td>
</tr>
<tr>
<td>Two nurses from the education department</td>
<td>$400.00 ($25.00/hour x 8 hours each)</td>
</tr>
<tr>
<td>Honorarium for expert speaker</td>
<td>$500.00</td>
</tr>
<tr>
<td>Total:</td>
<td>$2,000.00</td>
</tr>
</tbody>
</table>

Box 4-1: SWOT Analysis Case Study

Jane Williams is an RN with 3 years of nursing experience. Her career goal is to become a chief nursing officer (CNO) in a large urban teaching and research hospital. Currently, she is practicing on a general surgical unit in the local community hospital on the 7:00 a.m. to 7:00 p.m. shift and has been employed on this unit since her hire 3 years ago. She has assumed the charge nurse role on weekends for the past 2 years and has had some “run ins” with hospital supervisors regarding pulling nurses from the surgical unit, despite the fact that their patient classification system acuity tool supports that they are over staffed.

Ms. Williams holds a Bachelor of Science in Nursing (BSN) degree and does not hold any specialty certifications. She graduated with high honors (magna cum laude) when she received her BSN degree.

Ms. Williams lives with her husband and 6-year old child. Her husband is employed full time as a quality controller at a local food factory. Her son attends the local elementary school and takes the bus to and from school.

Ms. Williams wants to move forward with her career and is contemplating her next action.

Figure 4-2: Completed SWOT Analysis for J. Williams

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-year track record for employment at the hospital</td>
<td>Does not hold a higher degree in nursing</td>
</tr>
<tr>
<td>Graduated with high honors with a BSN degree</td>
<td>Has not held formal management position; i.e., assistant nurse manager</td>
</tr>
<tr>
<td>Supportive family</td>
<td>Not cooperative with nursing supervisors</td>
</tr>
<tr>
<td>Excellent clinician</td>
<td>Does not hold certification in any field</td>
</tr>
<tr>
<td>Strong desire to further her formal education</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Opportunities</th>
<th>Threats</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital has a tuition reimbursement program available when continuing education budget has funds</td>
<td>Hospital is sending a finite number of nurses to school for higher degrees</td>
</tr>
<tr>
<td>Has time in her life to attend a weekends only MSN program</td>
<td>Experienced RNs who hold the MSN degree in Nursing Service Administration</td>
</tr>
<tr>
<td>Neighboring hospital is expanding patient care units and will be hiring nurses in staff and management positions</td>
<td>Immediate past evaluation cited concerns with coworkers regarding communications</td>
</tr>
</tbody>
</table>

Deliver safe and adequate patient care, a nurse may have to work a holiday when he or she was supposed to have it off. In this scenario, there is no solution to some nurses working the extra holiday.

The literature cites different problem-solving models. The nursing process is the scientific problem-solving process in the nursing profession. The steps of the process – assessment, planning, diagnosing, implementing, and evaluating – are used in managing patient problems.

The Program Evaluation and Review Technique (PERT) is a tool to show the sequence of tasks needed to complete a plan. For example, a change in procedure may require multiple steps to prepare staff members’ acceptance of the change. Examples include that new policies or procedures must be written, staff must be educated regarding changes, and any additional equipment and supplies must be available prior to implementing the changes. By identifying all of the necessary preparations and establishing a timeline for their completion, the nurse manager can predict and plan a completion or implementation date.

Problem solving encompasses the decision-making process. Unlike decision making, in which a problem may not exist, a triggering event can indicate the need for an action or intervention to facilitate a needed change. For example, a hospital initiated a new pain management protocol for breakthrough pain on the oncology unit. Five new nurses have been hired within the last 3 months, and all are novice nurses. Nurses must have a solid understanding of the pain management protocol for breakthrough pain because all of the patients on the oncology unit have a cancer diagnosis. Before trying to solve this problem, the nurse providing patient care must ask certain crucial questions, including:

1. Is the issue important?
2. Am I the person responsible for the problem?
3. Am I qualified to manage the problem?
4. Do I have authority to intervene?
5. Do I have the knowledge, interest, time, energy, and resources to manage the problem?
6. Can the problem be delegated to another capable person?
7. Will there be benefits from resolving the issue? (Yoder-Wise, 2011)

If the answers to the first five questions are “no,” the nurse need not proceed, but should refer the problem to a person who can manage the issue, such as the oncology nurse manager, the clinical nurse specialist, or the education director. If the answers to these questions are “yes,” the nurse accepts the challenge and accepts accountability for seeing that the issue is addressed.

If the nurse answers yes to the first question and no to the remaining questions, the director should be consulted to determine who is qualified to manage the issue.

Steps in the Problem-Solving Process

Problem solving involves using an organized process to solve an issue. The basic steps in the problem-solving process are:

- define the issue or problem of concern
- collect data
- analyze data
- develop interventions
- select an intervention
- implement the intervention
- evaluate the intervention.

These key steps in the problem-solving process are graphically represented in Figure 4-3.

Step 1: Define the issue or problem. It is essential in this step to take the time needed to correctly identify the issue. People identify problems based on their personal values, experiences, and attitudes. Therefore, it is imperative that a group or committee of people work collectively to resolve issues. Kritek (2002) recommends that quality time be taken in Step 1 to facilitate outlining as many options as possible. Looking at the strengths that each person in the group brings to the table may allay feelings of distress if a person speaks up. Looking at collective strengths of the group can foster the problem-solving process. Questions to ask include:
BOX 4-2: SWOT ANALYSIS FINDINGS FOR J. WILLIAMS

Based upon the SWOT analysis for Jane Williams, some “take home” messages are identified.

1. Cooperate with hospital supervisors. Hospital supervisors are in a position to make recommendations for attendance at graduate school. Most staff nurses do not like being pulled; however, Jane Williams was in a charge nurse position and should have cooperated with supervisors. The staffing on her unit after the nurse was pulled was adequate.

2. Be proactive with meeting career objectives. Jane Williams is eligible to write the certification exam for nurse executives because she has 2 years of experience as a charge nurse. When applying for a permanent charge nurse position or assistant nurse manager position, certification can make the application stand out.

3. Broaden the nursing background. Jane Williams could have posted to another general medical-surgical unit to gain different clinical experiences and interact with a new nursing team and different physicians. The more people that the nurse works with increases the number of people who can provide references.

4. Communicate goals to nurse managers. Nurse managers can advise on how to progress within the hospital organization and are familiar with the hospital policy on tuition reimbursement. The immediate supervisor will most likely be a formal reference for the candidate and, therefore, needs to be aware of career goals so coaching and mentoring can be provided.

5. Attend conferences on communication techniques. Most hospitals and healthcare agencies have funding for staff nurses to attend conferences for professional development. Take advantage of this benefit!

6. Attend available staff development sessions within the hospital or healthcare organization. This communicates to others a desire to learn. In Jane Williams’ case, it may also convey acknowledgment of her issues with communication and her desire to make positive changes in the workplace.

<table>
<thead>
<tr>
<th>Define problem</th>
<th>Collect data</th>
<th>Analyze data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implement</td>
<td>Select intervention</td>
<td>Identify interventions</td>
</tr>
<tr>
<td>Evaluate</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- What do I bring to the table?
- What are the real issues?
- What is the main strength of the assigned group of professionals?

**Step 2:** Collect data. After the main problem has been identified, as much information as possible must be collected for the purpose of problem resolution. Objective data as well as the subjective feelings of those involved, should be identified during data collection. Each member of the group must have access to all information collected.

**Step 3:** Analyze data. The data are studied and the initial problem may be further refined. The team must differentiate a problem versus a potential indication of a problem. For example, hospital policy is that nurses must document in patients’ charts within 30 minutes of the time that medications are given. A spot audit supports that several patients’ medical records do not have electronic entries for medication delivery scheduled for 9:00 a.m. Does this information support that medications were not given, or does it mean that the nurse is late in documentation? On further inspection, the supervisor discovers that the electronic system for the pharmacy was malfunctioning. By determining the exact nature of the problem, an appropriate solution can be implemented.

**Step 4:** Identify interventions. As many interventions as possible should be generated. After a range of options is determined, the group should employ critical thinking to determine which interventions are feasible, affordable, and likely to succeed.

**Step 5:** Select an intervention. After determining which interventions are least likely to succeed, too costly, or do not match the organization’s way of doing business (organizational culture), the interventions should be ranked ordered. The intervention that is deemed most likely to be successful must be selected.

**Step 6:** Implement. Implementation of the intervention occurs at this level. The group should be ready to change to the second best intervention as a back-up plan.

**Step 7:** Evaluate. The tools to evaluate the outcomes of the intervention must be in place. Certain questions should be answered early in the problem-solving process, such as:
- Who will monitor the implementation process?
- Who will evaluate the process?
- What determines whether the intervention is complete?
- What result will be acceptable to the group?

This seven-step process may be cumbersome to some; however, it ensures that every avenue of a problem has been reviewed. Learning from the process, mistakes made, and achievements can improve problem-solving techniques for future issues. Problem-solving processes can be successfully managed and learned by involved nurses.

**Creativity**

Creativity is necessary for the production of as many ideas as possible so that issues can be resolved efficiently. For this reason, when task forces, groups, and committees are arranged, diversity is essential. It is best to have people from different backgrounds critically look at all aspects of an issue. To facilitate creativity on a committee, the following aspects of group selection must be considered:
- Does the person bring a unique background to the group?
- Is the person a risk taker?
- Is the person respected among his or her colleagues?
- Does the person employ humor in his or her work?
- Can the person think critically?
- Is the person flexible in his or her thinking?
- Can the person think critically?

The qualities of each individual are important to the group dynamic. Creativity and independence in thought processes can go a long way toward effectively managing issues. The nurse leader must model these abilities and encourage these attributes in others.

**SUMMARY**

Decision-making tools and problem-solving processes can assist nurses in resolving issues and making informed choices. These formalized tools also facilitate collaboration with other members of the healthcare team, including administrators, and help to keep a decision-making process unbiased and objective.
Leadership and Management for Every Nurse

**CHAPTER OBJECTIVE**

After completing this chapter, the learner will be able to:

1. Differentiate among capital, operating, and human resource budgets.
2. Describe ways that nurses can impact healthcare agency costs.
3. Explain staffing and staff mix for patient care units.
4. Explain the difference between productive and nonproductive hours.
5. Describe the differences between fixed and variable costs.
6. Determine how unit productivity is measured.

**RESOURCES**

- California Academic Press
  - http://www.insightassessment.com/About-Us/
- California-Academic-Press
- Center for Critical Thinking and Foundation for Critical Thinking at Sonoma State University
  - http://www.criticalthinking.org
  - Quality Safety Education for Nurses
  - http://www.qsen.org

**CHAPTER 5: RESOURCE MANAGEMENT**

Nursing care delivery today is very different than it was several years ago. Nurses today are more involved in cost containment, especially nurses in management roles. Historically, nurses were not educated to manage budgets. Their basic education focused on skill acquisition and learning patient care techniques.

Nurses in current practice have the same issues of delivering quality care; however, changes in health care require that staff nurses be knowledgeable about fiscal management and have economic savvy. For these reasons, staff nurses must be aware of staffing plans and full-time equivalent (FTE) allotments for their assigned units and must have basic knowledge of operating, human resources (personnel), and capital costs of patient care.

Information within this chapter reviews budget principles. On completion of the chapter, the reader will be able to explain different human resource concepts. Additionally, the learner will be able to determine the nursing care hours that should be delivered according to established formulas, to help gauge the direct, “hands-on” care hours a patient can expect to receive. This understanding will be accomplished through completion of case studies that pose budget situations.

One of the greatest challenges a nurse manager will encounter is completing the work schedule for staff nurses on his or her assigned unit. An aging workforce, staff burnout, increased patient acuity, and job dissatisfaction can lead to staff nurse turnover. This chapter explores variables that affect nurse staffing, shares information on self-scheduling, and identifies strategies that can augment nursing personnel on patient care units.

Creative use of a mixed (different roles), skilled workforce to supplement registered nurses (RNs) and licensed practical nurses (LPNs) or licensed vocational nurses (LVNs) can enhance unit productivity and increase direct hands-on nursing care. Patient classification systems help guide nurses in their assignment decisions.

**MANAGING RESOURCES**

Fifty years ago healthcare delivery was easier; physicians, members of the healthcare team, and administrators worked collaboratively, with government and business on the periphery (Swayne, Duncan, & Ginter, 2008). Healthcare delivery and access to care are now large political issues with politicians seeking high offices. Policy initiatives, such as the Affordable Care Act enacted by President Obama, have opened the door for all Americans to have access to health care. The intention of these types of initiatives is to help uninsured and under-insured citizens; however, they create challenges for healthcare administrators.

Costs of such technologies as electronic medical records software programs are expensive, and smaller community hospitals with lower patient census have to manage their resources carefully. An aging citizenry, coupled with advances in medicine in such areas as imaging sciences, minimally
invasive surgeries, and drug design delivery systems, drive healthcare costs up. Health care is one of the largest industries in the U.S. and employs many people (Morris, 2007). Managing resources and employing competent physicians, nurses, and other healthcare professionals and excellent administrators, as well as knowing and understanding all aspects of the budget process, is crucial to the success of healthcare agencies.

**BUDGETS**

Budgets are classified into three major categories: operating, capital, and human resources. Nurses must have a working knowledge of all three budget types to deliver cost-effective care. (See Table 5-1.) The following sections review these different budgets and illustrate examples of the materials, equipment, and personnel that are covered in each budget category.

**Operating Budget**

Nurses have great control over operating budget expenses, which account for income and expenses that are generated on a daily basis within each department in a healthcare organization (Finkelman, 2012; Yoder-Wise, 2011). Revenue generation is based on billable services and expenses associated with equipment use, supplies, and other indirect costs. When nurses do not discharge a patient at the correct time, or incorrectly input a patient’s status as “inpatient” versus “outpatient,” the healthcare agency’s operating budget is adversely affected because the patient’s length of stay is increased.

Another example of an adverse impact on an agency’s operating budget is when a nurse does not contact a social worker or case manager for patients needing to return to the nursing homes from which they were admitted. This type of action exacerbates expenses incurred by agencies and contributes adversely to the “out of control” healthcare costs. Such referrals should be made by the nurse when the patient is admitted to the unit. Patients’ lengths of stay increase when nursing home beds are not secured for expected discharge dates. Social workers and case managers are skilled professionals who can serve the patient and healthcare agency by facilitating a timely discharge from the hospital.

Nurses can exercise control over daily consumable supply use. Efficient and effective use of these products and supplies decreases waste, thereby creating a cost savings to the healthcare agency. Sometimes, costs are included in the cost of a procedure or daily room rate charge. An example is supplying each patient with a wash basin, comb, toothbrush, toothpaste, soap, and lotion as part of the hospital room charge. Whereas charges for intravenous (IV) start kits, blood filters, and IV flush solutions usually are incurred separately and must be reflected accurately when using such items.

Other ways in which staff nurses can be conscientious about cost containment include:
- using equipment only for its intended use
- using an established system for charging supplies and equipment
- signing out supplies only to the specific patient who used the items.

**Capital Budget**

The capital expenditure budget reflects costs related to major expenses, such as equipment and the physical plant. The useful life of a capital expense is greater than 1 year and exceeds the maximum cost for operating expenses established by the healthcare organization (Yoder-Wise, 2011). An example of a capital item may be an IV pump controller (for drip rate) that costs $4,000. Another example of a high cost item is adding a building to the physical plant.

The dollar amount set by each healthcare organization for purchase of capital items is different. Yoder-Wise (2011) reports that the range for a capital budget item request is between $300 and $1,000, although some organizations have a much higher cap. A capital budget also provides a plan for long-term investments (Finkler, Kovner, & Jones, 2007). This budget can include expensive equipment within the capital budget range or more expensive purchases such as land to expand the physical plant.

A nurse manager may be authorized to purchase a more-expensive piece of equipment for his or her unit out of the supply budget. An example of this may be an orthopedic nurse manager who wants to purchase a continuous passive motion machine that costs $2,500 for patients to use after total knee arthroplasties. The nurse manager could justify the expense by stating that earlier joint exercise contributes to patient recovery and cuts the length of hospital stay for each patient by 1 day.

Every nurse manager must become familiar with justifying capital budget items as part of his or her unit’s budgeting plan. It is not enough to say, “I need five new electric beds”; the manager must provide justification for this expenditure. When a capital purchase is moved forward to the next level administrator, the nurse manager must have completed written justification for the capital equipment. (See Figure 5-1 for an example for a capital expense justification form.) The nurse manager must conduct prior investigation of the equipment’s cost and impact on revenue and share information that can further justify the cost. Describing how equipment can provide a cost savings or maintain or enhance patient and staff safety on the nursing care unit are excellent ways to justify a capital expense. The nurse manager also needs to develop a timeline to make sure the project stays on schedule (Swayne et al., 2008).

Each healthcare organization has different ways of approving capital expenditures, such as requiring the immediate supervisor to sign off or sending the capital request through a capital expenditure committee review. Depending on the amount of the purchase, it may have to be approved by the Chief Operating Officer or the Chief Executive Officer.

**Human Resources**

Nurses account for the greatest portion of a hospital’s human resources budget, accounting for 33% of the organization’s personnel budget. The human resources budget reflects the persons needed to provide direct and indirect patient care (Huber, 2010). Direct care is defined as the “hands-on” care given to a patient. Direct care hours include time spent providing individual patient care as well as care to a group of patients. The most common mix of direct care staff includes the RN, LPN, and unlicensed assistive personnel (UAP).

Indirect care accounts for time spent on activities that are patient related, but are not related to actual hands-on care provided to the patient. Examples of a nurse’s indirect care activities that support the patient, consume the nurse’s time, and must be accounted for in the personnel budget, but are not direct hands-on patient care, include:

- Picking up narcotics for the unit from the hospital pharmacy

<table>
<thead>
<tr>
<th>TABLE 5-1: OPERATING, CAPITAL, AND HUMAN RESOURCES BUDGETS</th>
</tr>
</thead>
<tbody>
<tr>
<td>This table presents examples of items within the three types of healthcare organization budgets. Note that the dollar amount set by the organization determines whether a cost (expense) is an operating budget cost or a capital budget cost. Often, labor costs, which include nurses’ salaries, are lumped into the operating budget.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Budget</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operating</td>
<td>• IV tubing</td>
</tr>
<tr>
<td></td>
<td>• Cotton halls</td>
</tr>
<tr>
<td></td>
<td>• Tongue depressors</td>
</tr>
<tr>
<td></td>
<td>• Repair of a blood pressure cuff</td>
</tr>
<tr>
<td></td>
<td>• Urinary catheter kit</td>
</tr>
<tr>
<td></td>
<td>• 4 x 4 dry sterile dressings</td>
</tr>
<tr>
<td>Capital</td>
<td>• Purchase of land for hospital expansion</td>
</tr>
<tr>
<td></td>
<td>• Physical plant</td>
</tr>
<tr>
<td></td>
<td>• Purchase of land for additional parking</td>
</tr>
<tr>
<td></td>
<td>• Computer terminals in client rooms</td>
</tr>
<tr>
<td></td>
<td>• Electrocardiogram machine</td>
</tr>
<tr>
<td></td>
<td>• Ventilators (respiratory)</td>
</tr>
<tr>
<td>Human Resources (Personnel)</td>
<td>• Nurse registry costs</td>
</tr>
<tr>
<td></td>
<td>• Consultant fees</td>
</tr>
<tr>
<td></td>
<td>• 4-hour CPR inservice</td>
</tr>
<tr>
<td></td>
<td>• Overtime</td>
</tr>
<tr>
<td></td>
<td>• Nurses’ salaries (8- or 12-hour shifts)</td>
</tr>
<tr>
<td></td>
<td>• Float pool nurses</td>
</tr>
</tbody>
</table>
Leadership and Management for Every Nurse

Working 40 hours per week is considered full-time and represents one FTE (Finkler et al., 2007; Yoder-Wise, 2011). Nurse staffing schedules are usually based on working 80 hours in a 2-week period. Nurses can work either full-time or part-time, based on their personal preferences and position availability. Working anything less than 40 hours per week typically reflects part-time status; however, in some healthcare organizations a 36-hour week is considered full-time because nurses are working 12-hour shifts in the facility’s patient care units. Healthcare organizations give full benefits or a reduced portion of benefits to nurses who work part-time. Irregular part-time status is usually designated to nurses working four shifts or less per pay period. One full-time nurse is considered 1.0 FTE, or 2,080 hours annually, for budget purposes (see Table 5-2).

WORK HOURS

Nurse managers must account for how nurses spend their time during their assigned shifts. A portion of each nurse’s time is spent gathering supplies and looking for assistance to transfer patients. Although these different activities are important, they do not contribute to the direct care of the patient. The next section accounts for how nurses spend their time on duty and addresses benefit time that each full-time employee receives.

PRODUCTIVE AND NONPRODUCTIVE HOURS

A nurse employed full-time works 2,080 hours annually (1 FTE), which includes productive as well as nonproductive hours (Finkler et al., 2007; Yoder-Wise, 2011). Productive hours reflect the hours a nurse works and is available for direct hands-on patient care. Nonproductive hours include sick time, vacation time, bereavement time, holidays, orientation time, and staff development and education time. Available productive hours are easily calculated by subtracting nonproductive hours from the employee's full-time status. See Figure 5-3 for a calculation of productive and nonproductive time for a full-time (2,080 hours annually) employee. See Box 5-1 to practice basic budget calculations.

NURSING CARE HOURS

Calculating direct hands-on care is important to nurses and health care organizations’ finance departments. Nurses must be savvy in quantifying patient care and establish an objective measure of their caregiving hours. A basic formula for determining nursing hours per patient day (NHPPD) is:

\[ \text{Total number of direct caregivers in a 24-hour period multiplied by an 8-hour shift and then divided by the average occupancy (daily census).} \]

For example, the NHPPD in Figure 5-2 reflects 14 direct caregivers \( \times \) 8 hour shift = 112. Then divide 112 by the average census of 22 = 5.09 direct care hours. Box 5-3 shows how staffing changes can alter direct care hours.

COSTS AND EXPENSES

Costs and expenses vary by healthcare institution. Direct expenses are directly tied to a patient and include consumable supplies and medications (Clark, 2009). Indirect expenses include utility costs, such as gas, water, electric, and telephone charges and cannot be directly tied to a patient.

Fixed costs include expenses that are constant and do not change with volume or patient acuity (Yoder-Wise, 2011). Variable costs fluctuate depending on patient census, acuity, and the extent of care required. Consumable supplies, medications, laundry, and meals are examples of costs that increase with patient volume.

Charges and cost-based compensation are retrospective payment methods because the amount of reimbursement is determined after services are rendered. When reimbursed costs are less than the full charges incurred by the hospital, a contractual allowance has occurred (Yoder-Wise, 2011). A contractual allowance is a discount from the full charge.

STAFFING

Assigning nurses to cover patient care 24 hours a day, 7 days a week is an awesome responsibility for a unit manager! The nurse manager hires nurses to meet the care demands on a unit of service. Staffing involves hiring, orienting, and deploying qualified nurses to meet the demands for patient care (Clark, 2009). The unit of service determines which levels of caregivers are needed. For example, a critical care unit may need an all-RN staff if it is a large referral center that admits high-acuity patients. On the other hand, a physical rehabilitation unit may be able to meet the demand for nursing care by having fewer RNs and more LPNs, LVNs, and UAP.

Staff Mix

The proportion of RNs, LPNs, LVNs, and UAP comprises the staff mix (Finkelman, 2012). Staff mix can vary by unit, illness level or patient acuity, and by days and times during the week. Commonly, surgical units are busier during the week, which is when surgical cases are scheduled.
operating room (OR) schedule is largely determined by surgical cases called to the OR by physician offices so they can be scheduled. Therefore, general and specialty surgical units are typically busier Monday through Thursday, with many patient discharges occurring at the end of the week and on weekends. Additionally, more-complex cases are usually scheduled at the beginning of the week.

Assessment and initial planning are aspects of the nursing process that come under the purview of an RN. More RNs are needed to assess patients at the time of admission and for initiating plans of care. Emergency departments (ED) are usually busier on weekends and during the evening and night shifts; therefore, a greater number of RNs may be scheduled during these time periods. Critical care units usually have peak busy times in the morning, when they are transferring patients to general medi-

This figure presents a schematic representation of a sample staffing plan for an orthopedic surgical trauma unit. It is noteworthy that there are no UAP in this staffing plan; however, a cast technician is available on the unit.

Bed capacity: 26   Average occupancy: 22

<table>
<thead>
<tr>
<th></th>
<th>DAY SHIFT 7-3:30 p.m.</th>
<th>AFTERNOON SHIFT 3-11:30 p.m.</th>
<th>NIGHT SHIFT 11-7:30 a.m.</th>
</tr>
</thead>
<tbody>
<tr>
<td>NM</td>
<td>1 FTE</td>
<td>Asst. NM 1 FTE 0.4 FTE</td>
<td>Asst. NM 1 FTE</td>
</tr>
<tr>
<td>RN</td>
<td>1 FTE 0.4 FTE</td>
<td>RN 1 FTE 0.4 FTE</td>
<td>RN 1 FTE 0.4 FTE</td>
</tr>
<tr>
<td></td>
<td>1 FTE 0.4 FTE</td>
<td>1 FTE 0.4 FTE</td>
<td>1 FTE 0.4 FTE</td>
</tr>
<tr>
<td></td>
<td>1 FTE 0.4 FTE</td>
<td>LPN 1 FTE 0.4 FTE</td>
<td></td>
</tr>
<tr>
<td>LPN</td>
<td>1 FTE 0.4 FTE</td>
<td>LPN 1 FTE 0.4 FTE</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 FTE 0.4 FTE</td>
<td>1 FTE 0.4 FTE</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 FTE 0.4 FTE</td>
<td>UC 1 FTE 0.4 FTE</td>
<td></td>
</tr>
<tr>
<td>UC</td>
<td>1 UC 0.4 UC</td>
<td>(43%)* **</td>
<td>(36%)* **</td>
</tr>
</tbody>
</table>

Staffing plan allows 5.09 direct care hours per 24-hour period. This unit also employs an orthopedic technician (1.0 FTE), who is not included in the staffing plan.

NM = Nurse Manager; Asst. NM = Assistant Nurse Manager; UC = Unit Clerk

The Cast Technician provides support for patients throughout the entire hospital; therefore, the position is not included on the staffing plan.

* = percentage of hands-on caregivers per shift in a 24-hour period – total = 100%
** = part-time employees who provide replacement for full-time staff

25.8 Personnel FTEs (productive hours)
3.2 Benefit FTEs (nonproductive hours)
29.0 TOTAL FTEs

This table shows how employment status is calculated. Benefits according to employment status vary by institution.

<table>
<thead>
<tr>
<th>Hours per Pay Period</th>
<th>Employment Status</th>
<th>FTE Assigned</th>
</tr>
</thead>
<tbody>
<tr>
<td>80</td>
<td>Regular full-time</td>
<td>1.0</td>
</tr>
<tr>
<td>72</td>
<td>Regular full-time</td>
<td>0.9</td>
</tr>
<tr>
<td>64</td>
<td>Regular full-time</td>
<td>0.8</td>
</tr>
<tr>
<td>56</td>
<td>Regular full-time</td>
<td>0.7</td>
</tr>
<tr>
<td>48</td>
<td>Regular part-time</td>
<td>0.6</td>
</tr>
<tr>
<td>40</td>
<td>Regular part-time</td>
<td>0.5</td>
</tr>
<tr>
<td>32</td>
<td>Regular part-time</td>
<td>0.4</td>
</tr>
<tr>
<td>24</td>
<td>Regular part-time</td>
<td>0.3</td>
</tr>
<tr>
<td>16</td>
<td>Irregular part-time</td>
<td>0.2</td>
</tr>
<tr>
<td>8</td>
<td>Irregular part-time</td>
<td>0.1</td>
</tr>
</tbody>
</table>

Vacation time 4 weeks annually or 20 days = 160 hours
Illness time 1 week or 5 days = 40 hours
Holiday time 1 week or 5 days = 40 hours
Staff development time 4 days = 32 hours
Total nonproductive time = 272 hours
2080 – 272 = 1808 productive hours for a full-time nurse with these benefits.

1. If the percentage of productive hours is 80%, how many productive hours are there per FTE? How many nonproductive hours?
2. If total patient care hours are 82,420 (based on 80% productive hours), how many FTEs are needed?
3. If a nurse works two 12-hour shifts and three 8-hour shifts per pay period, what is the FTE worked per 2-week pay period?
4. A contractual allowance occurs when the reimbursed costs are less than the full charge for service. What is the contractual allowance when a hospital charges $1,000/day to care for a ventilator-dependent patient and the insurance company reimburses the hospital $800/day? What would the impact on hospital income be if this is the reimbursement for 2,500 patient days?

See Box 5-2 for answers to these questions.
BOX 5-2: ANSWERS TO BUDGET PROBLEMS

1. 2080 × 0.8 = 1,664 productive hours
   2080 × 0.2 = 416 nonproductive hours
2. 82,420 ÷ 1,664 productive hours = 49.5 FTEs needed to produce these patient care hours
3. Two 12-hour shifts = 24 hours
   Three 8-hour shifts = 24 hours
   24 + 24 = 48 hours per pay period
   80 hours per 2-week pay period equals 1 FTE; in this case, the hours worked (48) is divided by the hours for 1 FTE (80) and results in 0.6, which is the FTE the nurse worked during the 2-week pay period.
   The nurse works 0.6 FTE per pay period.
4. $1,000 - $800 = $200 contractual allowance
   $200 × 2500 patient days = $500,000

This amount represents a loss of revenue to the hospital for the care of these patients.

BOX 5-3: CASE STUDY – DIRECT CARE HOURS

Use the staffing plan depicted in Figure 5-2 to answer the questions posed in this case study.

An orthopedic nurse manager is experiencing a temporary span of high patient acuity due to a bus accident. The average occupancy on the orthopedic unit has not changed. Both assistant nurse managers are counted as management and not as direct hands-on caregivers. The nurse manager decides to use her assistant nurse managers as direct hands-on caregivers in the next 24-hour period.

1. How does this impact the NHPPD in a 24-hour period on the orthopedic unit?
2. What other strategies can the nurse manager employ to increase the NHPPD in a 24-hour period?

See Box 5-4 for answers to these questions.

BOX 5-4: ANSWERS TO CASE STUDY – DIRECT CARE HOURS

1. Using the formula to determine NHPPD, the outcome is as follows:
   16 nurses × 8 hour shift (128) ÷ 22 = 5.81
   5.81 - 5.09 = 0.72
   0.72 × 60 (60 minutes in 1 hour) = 43.2
   There are 43.2 additional minutes in the 24-hour period.
2. The nurse manager can employ several strategies to increase the NHPPD. The nurse manager could function in a charge nurse role and provide direct patient care. He or she could also call in part-time nurses to assist during the period of high acuity, call in agency nurses, offer overtime to currently working orthopedic staff nurses, and ask the central nursing office to send a float nurse to the orthopedic unit.

Staff mix will vary depending on the type of nursing unit. For example, an all RN staff is easily justified when practicing in a critical care unit. A surgical unit may employ more RNs on an afternoon shift because that is when patients return from the OR. During this time period more frequent assessments, such as pain management and ensuring the stability of vital signs, are done. Also, patients may require pain intervention that requires the attention of a licensed nurse.

Physical rehabilitation units and skilled care units are busiest during mealtimes, when patients need extra assistance because of such conditions as paralysis, paresis, and dysphagia (Sullivan & Decker, 2005). Evening hours also pose greater nursing care demands, with patients needing assistance to return to bed and to complete activities of daily living (ADLs). The use of UAP is often seen on rehabilitation units because some of the care demands do not require a nursing license and are within the job duties outlined in the position description. During the day, patients may be away from the unit working with therapists, depending on their diagnoses or disabilities.

**Staffing Plans**

The unit staffing plan is developed by considering the admission trends and case mixes from previous years. The approved personnel budgets from previous years serve as a guide for determining the major staffing plan for the coming year. Nurse executives ask the following questions when developing or revising staffing plans:

- What are the hours of operation? Does the unit operate 24 hours a day, 7 days a week? Does the unit have finite hours of operation (i.e., same-day surgery)?
- Are shifts 8 hours, 12 hours, or shortened 4-hour shifts covering peak hours of operation and acuity?
- How much call time will be used?
- What is the policy for overtime and weekend coverage?

**Fixed Versus Flexible Full Time Equivalents**

The master staffing plan involves employees who are in fixed positions and variable positions (Yoder-Wise, 2011). An FTE describes a person who works full-time at the healthcare institution. Fixed personnel are those employees who remain constant to facilitate unit operations and do not vary based on patient census and acuity. Examples include the nurse manager, unit educator, and unit secretary. At times, assistant nurse managers are considered a fixed cost on the unit staffing plan. Some of these employees are salaried, which means that their compensation does not depend on unit workload.

Variable FTE positions are held by employees who are scheduled to work based on unit census (capacity) and acuity (Finkler et al., 2007; Yoder-Wise, 2011). Staff nurses, UAP, and supplementary personnel are typically in these positions.

**Block Staffing**

Many nursing units use block staffing. Block staffing entails scheduling a fixed staff mix for each shift (Sullivan & Decker, 2005). Staffing for general medical-surgical units may have the greatest number of nurses on the day shift, when all bathing and hygiene care is provided and preparation of patients for scheduled procedures occurs (including going to the OR). On these units, the number of nurses may be greatest on the day shift, followed by the afternoon shift, when patients are still awake and involved in getting in and out of bed or having scheduled procedures such as surgical dressing changes. Night shifts typically are involved in assessment, medication delivery, administration of intravenous medications, and answering call lights. Therefore, the compliment of staff is lowest on this shift, especially for general medical-surgical units.

**AGENCY, STATE, FEDERAL, AND REGULATORY GUIDELINES FOR NURSE STAFFING**

Agency policy provides guidelines for the nurse manager to use to schedule nurses in a fair and equitable way (Ellis & Chapman, 2006; Yoder-Wise, 2011). Furthermore, managers need to be aware of state and federal laws relative to staffing, many of which came about because of the nationwide shortage of licensed nurses. For example, California has mandated minimum staffing requirements for critical care units and emergency departments (Stone & Plumb, 2011). Healthcare legislation, the Patient Protection and Affordable Care Act, was passed in March of 2010 that provided more citizens with health insurance, which impacts nurse staffing (Finkelman, 2012). This legislation made provisions for initiating a Workforce Advisory Committee to develop a national strategy...
to address shortages of healthcare professionals through the provision of loans and scholarships to attend educational programs. This included supporting advanced practice nurses (APNs) to augment geographic areas with medical staff shortages.

Regulatory agencies are becoming more cognizant of staffing issues and are looking for quantitative measures to put in place to guide staffing. The Joint Commission reviews quality care issues and determines each hospital’s ability to meet patient care demands. The Joint Commission also looks to see if a hospital is using an objective and quantifiable scheduling system and has policies and procedures in place that govern the hospital (healthcare agency) and nursing plans of care.

**AUGMENTING STAFFING**

The use of UAP to augment licensed nurses has gained much attention in the literature. It can create additional burdens on the RN’s time because this level of worker requires more direct supervision. Unlicensed assistive personnel (UAP) can be contributing members of the healthcare team; however, this necessitates quality in-service education, supervised on-the-job training, and a standardized program that teaches the UAP the skills needed to function optimally in a healthcare setting. Supervising UAP requires that the RN give specific directions and provide frequent follow-up to give feedback. This all takes time—time that the RN does not always have (Finkelman, 2012).

**FACTORS AFFECTING NURSE STAFFING**

The nursing shortage will continue to be an issue challenging all healthcare organizations—an issue that will not be resolved any time soon. Several organizations have published information about the nursing shortage; according to the American Association of Colleges of Nursing (AACN, 2012) there will be greater than 260,000 vacancies by 2025. Over 100,000 RN hospital positions are unfilled and another 100,000 vacancies for both RNs and LPNs are seen in the nursing home industry. Therefore, nurse executives need to be creative in staffing patient care units to ensure safe care delivery.

**Nurse Characteristics**

The primary mix of direct care providers in hospitals, long-term care centers, and nursing homes are RNs, LPNs or LVNs, and UAP. Nurses are of different ages and educational backgrounds and have different nursing experiences, including longevity in the profession (Yoder-Wise, 2011). The use of agency nurses and nurses who come to the U.S. from other countries for employment are also factors that must be considered when staffing units.

Research supports that patient outcomes related to patient safety are enhanced when a greater number of RNs are on duty (Ridley, 2008). A higher educational level of the nurse contributes to better patient outcomes. Research completed by Aiken, Clarke, Cheung, Sloan, & Silber (2003) supported that surgical patients experienced lower mortality and failure to rescue rates when they received nursing care from a greater proportion of baccalaureate-prepared nurses and those with higher degrees. Dunton, Gajewski, Klaus, & Pierson (2007) found that for every year of RN practice experience, hospital-acquired pressure ulcers and fall rates were reduced by 0.7% and 1%, respectively.

**Overtime**

Requiring nurses to stay at work when their scheduled shifts have concluded is mandatory, or mandated, overtime. In facilities with mandatory overtime, a nurse who refuses to stay could be subject to disciplinary action (Yoder-Wise, 2011). However, many nurses have other obligations, such as child care or caring for elder parents, and responsibilities that preclude them from working beyond their scheduled work hours. The effect of mandatory overtime on the nurse can negatively impact the quality of patient care, patient and staff safety, the health of the nurse, and nurse retention (Finkelman, 2012).

Regular overtime is when a staff member works longer than his or her scheduled shift if or has accepted the request to stay made by a nurse manager. In this case, the nurse may refuse the overtime without any consequences. The downside to nurses working overtime is that they may be fatigued and their decision-making abilities may not be as sharp as when they are well-rested.

**Agency Pools and Float Nurses**

The use of agency nurses, in-house float pool nurses, and overtime can temporarily assist a unit in meeting patient demands for nursing care. Nurses floating from one unit to another assist in covering patient care needs in peak acuity periods. A concern with this plan is that nurses may not be qualified to practice in the area in which they are asked to work. Some of these nurses have broad backgrounds as nurse generalists and are competent caregivers. These nurses can carry a normal patient load per the organization’s staffing plan; however, they may need assistance in using equipment that is specific to a unit’s specialty, such as a continuous passive motion machine, which is placed on patients after total knee arthroplasties.

Another option nurses may choose is working through external agency pools. In this arrangement, salaries are typically much higher, nurses are exposed to working with different professionals in different care settings, and they have travel opportunities. However, unlike in-house float pools, monitoring and evaluating agency nurses may be difficult.

The prudent nurse executive and nurse manager would check references, determine clinical competency areas, and interview float and agency nurses to determine where their skill sets best meet the needs of the organization (Finkelman, 2012).

**ORGANIZATIONAL FACTORS THAT AFFECT STAFFING PLANS**

Every organization manages staffing and scheduling differently. A nurse employed in a large, urban teaching and research hospital and another employed in a small, rural community hospital may encounter different issues with nurse staffing. Shift assignments and length of the shifts may also vary between institutions. These factors are usually addressed in the nursing division and may be addressed in the facility’s mission, vision, and philosophy statements. Agency policy and support structures in place also affect the nursing division’s staffing plan for all units.

**Philosophy Statement**

A philosophy statement reflects what the organization values. Therefore, models for staffing the unit are often adopted from the organizational philosophy to reflect values of the individual unit. Nurses follow through in carrying out the unit values in their care delivery. For example, if the nurses value teamwork, a team-based model of care delivery may be selected. Nurses who practice on an oncology unit may value more personal, one-to-one time with patients and their families and choose a primary care delivery model. It is important for the nurse executive to ensure that the model of care delivery selected by unit managers and staff nurses can be supported fiscally by the organization. Job dissatisfaction among nurses may result when they have a written philosophy statement that is incongruent with their values and care delivery system.

All necessary support structures and systems must be in place before nurses select a model of care delivery. For example, a primary care model would require a full complement of licensed nurses. The staffing model selected by a nursing unit determines the mix of staff needed to safely provide patient care.

**Organizational Staffing Procedures**

The staffing plan is a guide for the nurse manager in planning the day-to-day staffing for his or her assigned nursing care unit (see Figure 5-2). Staffing plans are developed by nurse executives, with input from nurse managers. The staffing plan directs the manager as to what the staff mix (RN, LPN or LVN, UAP) should be on a given shift. This plan also addresses the benefit time of each employee, which is accounted for in the unit budget. Requests for time off are usually based upon agency seniority, and the use of personal leave and vacation time are written into agency policies. Having these written policies in place lets employees know what the rules are relative to time away from work.

The staffing plan is based upon average patient census; therefore, if the unit’s average daily census increases, the manager can use that information to justify additional FTE’s to the unit’s budget. A factor the nurse manager needs to consider is requesting additional benefit time allotments to the unit’s budget if several longevity nurses are employed on the unit. A unit with several highly-experienced nurses with longevity to the organization saves money by decreasing the unit’s turnover and orientation costs. This is a good situation for any nurse manager to have; however, the overall budget needs to be critically reviewed and adjusted to accommodate the additional benefit time allotments.

**Organizational Support Systems**

Nurse managers need to determine what support systems are needed to keep staff nurses more engaged at the bedside. Several support systems can be put in place to keep nurses involved in direct patient care. Some examples of support services include:

- pharmacy technicians
- phlebotomists
- electrocardiogram (ECG) technicians
- logistics
- hospitality services
- clerical support.
An investigation conducted by Upenieks, Akhavan, & Kotlerman (2008) found that time spent doing value-added care activities were a direct benefit to the patient. Value-added care activities that were not direct care activities performed at the bedside or in the patient’s room included team collaboration, preparing medication, reviewing charts, teaching activities, and spending time with family members. These value-added activities benefited patients, improved workflow, and decreased the time that nurses spent in non-value-added activities. Examples of non-value-added activities include assisting with patient transport to the operating room and assisting with clerical roles.

**PRODUCTIVITY**

Measuring nurse productivity has historically been a challenge for nurse executives. Nursing care has been lumped into the bed charge for in-hospital patient stays. If nurse managers can provide care to a greater number of patients with their existing pool of budgeted nurses, their unit productivity increases (Finkler et al., 2007; Yoder-Wise, 2011).

Case type, depth of service, and patient acuity are factors that affect quality of care outcomes and staffing decisions (Yoder-Wise, 2011). Calculating nurse productivity is difficult for many reasons. Skill level, clinical judgment, and critical thinking levels differ based on a nurse’s education and experience, which makes it difficult to standardize the cost of care. Patient classification systems attempt to match the demands for nursing care with the supply of nurses. Nursing supply is abbreviated as a nursing care unit (NCU). A valid and reliable patient classification system justifies nurse staffing (human resources budget) and is a measure of unit productivity. Patient classification systems are different, depending on the unit specialty.

**PATIENT CLASSIFICATION SYSTEMS**

Patient classification systems are objective tools that quantify nurse workload requirements and staffing demands for patient care (Fasoli, Finke, & Haddock, 2011; Sullivan & Decker, 2005). Patients are classified according to severity of illness. Stone & Plumb (2011) reinforced that patient classification systems are an important variable for staffing decisions; however, they are not the only variable. Patient classification systems are not about nurses; they are about patients. The individual patient acuity level influences the unit to which the patient is assigned, care delivery system used, assignment made, and the cost of nursing services. All personnel levels within a hospital organization value patient classification systems as a patient care guide and as one mechanism to quantify nursing care delivery. One major drawback of most patient classification systems is that they do not differentiate between the level of caregiver needed (i.e., RN, LPN or LVN, UAP).

Valid patient classification systems help an organization fiscally because patient care assignments are made using an evidence-based tool (Stone & Plumb, 2011). An objective patient classification system takes emotion out of a staffing decision, and the assignment can be based upon matching the nurse’s skill level to the actual patient’s acuity. The use of a patient classification system increases organizational consistency by having a valid system that a new charge nurse can rely on to be an accurate measure of staffing needs. This staffing system assesses acuity on each shift and allows the nurse to act quickly to prevent understaffing and over-staffing, which can prevent higher hospital costs and litigation. Evidence-based patient classification systems for individual specialty units are becoming more prevalent and provide exact guidance in making objective assignment decisions that differentiate between the different nursing skill sets for RNs, LPNs, and UAP (Fasoli et al., 2011).

The nurse executive at Sharp Health Care, located in California, made it a priority to educate nurses on the use of the patient classification system. When the nurses understood how to use the patient classification system to analyze, track, and monitor staffing, productivity, and nursing budgets, they were able to replace emotion-related staffing decisions with patient classification system technologies that objectively guided patient care assignments (Stone & Plumb, 2011).

Time and motion studies quantify time needed to complete patient care tasks. Patient classification systems are completed each shift to determine the number of nurses required for care delivery (Sullivan & Decker, 2005). These systems are used for inpatient hospital units and direct the patient-to-nurse ratio for each scheduled shift (Fasoli et al., 2011). There are two major types of patient classification systems: factor and prototype.

**Factor System**

Factor systems are considered more objective than prototype systems because they allow the patient classification system tool to be quantified (Kelly, 2012; Yoder-Wise, 2011). Time and motion studies are conducted to assign a time or rating for individual procedures. For example, on the GRASP (Grace Reynolds Application and Study of PETO System) (Grace Reynolds Application and Study of PETO System), a seminal tool, each point in the factor patient classification system tool (called a patient care unit [PCU]), equates to 6.5 minutes. These acuity numbers are summed for each patient, and the number of nursing hours needed to care for patients on a unit (NCU) is determined. The PCU represents the demand for care, and the NCU represents the supply of nurses assigned to deliver care. A seminal time and motion study (Clark & Poland, 1976) validated acuity points on the GRASP factor patient classification system. The calculation in Box 5-5 depicts the total PCUs called to a central staffing office for a general medical unit.

**Prototype System**

The prototype classification system is considered subjective and descriptive (Kelly, 2012; Yoder-Wise, 2011). Patients with the same diagnoses are grouped together to predict care needs. One disadvantage of prototype systems is that they don’t account for the fact that each patient is different, even among those hospitalized for the same procedure, surgery, or diagnosis. For example, a frail, older adult male and a healthy 23-year-old male are both admitted to the hospital for appendectomies. However, the younger patient is independent in completing ADLs, whereas the older adult needs ADL assistance, requires more pain management, and needs help with toileting. Clearly, these patients’ demands for care differ, despite the same medical diagnosis.

**SCHEDULING**

Nursing schedules are constructed for a block of time. According to Yoder-Wise (2011), most agencies pay their staff every 2 weeks and post the completed work schedule for a 1-month period. There are two basic ways to prepare a work schedule: centralized and decentralized scheduling.

**Centralized Scheduling**

Centralized scheduling usually is done by a staffing coordinator, who typically works out of the main nursing office. There are several advantages and disadvantages of having a centralized scheduling coordinator (see Table 5-3).

Many larger organizations have computer software programs for nurse scheduling (Kelly, 2012). Inputting the staffing plans for every unit in the hospital ensures the integrity of minimum staffing requirements. The central staffing coordinator is responsible for inputting benefit time, documenting scheduling variances, running daily staffing records, and finalizing schedules.

Many hospitals have switched to automated systems for scheduling, which are easier for centralized schedulers and unit managers (Yoder-Wise, 2011). Automated systems can result in a win-win situation for staff nurses and hospital administrators because they facilitate nurse input into their daily schedule.

---

**BOX 5-5: PATIENT CLASSIFICATION SYSTEM**

The charge nurse on a medical unit calls the nursing office to report 420 PCUs for the oncoming 3 to 11:30 p.m. shift.

The nurse supervisor does the following calculation:

1. $1 \text{ PCU} = 6.5 \text{ minutes of nursing time}$
2. $420 \text{ (PCUs for the shift)} \times 6.5 \text{ (minutes)} = 2,730 \text{ (minutes of nursing time needed for patient care)}$
3. Each nurse on the unit works 7.5 hours
4. $7.5 \text{ (hours)} \times 60 \text{ (minutes in an hour)} = 450 \text{ (minutes of availability for each nurse)}$
5. $2,730 \div 450 = 6.07 \text{ nurses}$

Based on the calculations, 6 nurses are needed to staff the 3 to 11:30 p.m. shift on the medical unit.
work schedules, which has been linked to retention of nurses. The nurse manager reviews the initial schedule made by the computer, makes necessary revisions, and posts the final schedule.

**Decentralized Scheduling**

In decentralized scheduling systems, the nurse manager is usually the person responsible for completing and posting the final schedule (Yoder-Wise, 2011). A major disadvantage of this type of system is that the unit manager makes staffing decisions without knowing the “house” picture; however, a key advantage is that the manager is the person most knowledgeable about his or her unit’s staffing plan (see Table 5-4). In addition, managers are motivated to closely monitor their staffing schedules because they are responsible for their budgets and staff productivity.

**Self-Scheduling**

Self-scheduling may be done on units where shared governance models are used. Having no control over work schedules has been a major source of job dissatisfaction and departure from employment (Kelly, 2012). Self-scheduling involves staff nurses on the unit working collaboratively to implement the work schedule. Input into decisions related to work, which includes a “say” in scheduling, enhances morale and professionalism and retention in the workplace, which in turn reduces costs associated with nurse turnover (resignation) and saves time for the nurse manager (Finkelman, 2012). When employed successfully and implemented with adequate staff education, a self-scheduling system by unit nurses promotes autonomous decision making, responsibility, participation, and accountability; increases communication networks; and enhances negotiation skills.

Many benefits are associated with staff self-scheduling. Most nurse managers would agree that completing the staff schedule can be a colossal nightmare, which places inordinate demands on their time. Staff nurse involvement in the unit’s staffing provides insight into what the nurse manager does in her daily role. This exposure adds a different task into their repertoire of skills. Understanding the scheduling challenges that nurse managers face promotes cooperation and collaboration with the nursing staff.

**SUMMARY**

Nurses in the 21st century are poised to impact the quality of patient care as well as the economic and fiscal consequences of care delivery. It is now more important than ever for bedside nurses to have knowledge about the financial aspects of healthcare delivery and the impact of nursing on the fiscal strength of their healthcare organizations. When nurses assume this role responsibility, they are more likely to be successful in articulating why and how resources can be redirected to better serve patient care needs. The ability to speak to upper-level administrators about patient care issues and costs of care from a knowledge perspective (versus emotionally) makes staff nurses more effective in promoting the delivery of safe, cost-effective, and efficient patient care.

Staffing and scheduling are two of the greatest challenges facing nursing leaders today. Systems to quantify and justify the need for nursing care must be continually assessed, improved upon, and evaluated. Management models that promote nurse autonomy lead to greater decision-making capability in nursing practice and retention of nurses in the workforce. This is especially important now, when the nation faces a critical shortage of licensed nurses.

Patient classification systems, which facilitate nurse scheduling, and decentralized models of practice that include self-scheduling promote nurse autonomy and provide patients with a measure of safety as the demand for care escalates. Involving staff nurses in work schedule completion exposes them to the management aspect of the professional nursing discipline. It increases their understanding of staffing issues and the human resources budget.

An aging population and an aging workforce pose definite challenges for the future. Nurses must continue to be involved in issues that impact nursing practice and patient care outcomes. This can be accomplished by being active professionals within their healthcare organizations; seizing opportunities to learn more about fiscal management; attending available staff development and in-service sessions on issues related to staffing, scheduling, and budgeting; and obtaining an advanced degree in nursing to better understand and intervene in today’s healthcare environment.

**Answer the self-assessment questions for Chapter 5 at the end of the course.**

**TABLE 5-4: PROS AND CONS OF A DECENTRALIZED SCHEDULING COORDINATOR**

<table>
<thead>
<tr>
<th>Pros</th>
<th>Cons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Awareness of nurses’ capabilities for the assigned unit</td>
<td>Less knowledge of external agency staffing pools</td>
</tr>
<tr>
<td>Awareness of benefit use</td>
<td>Attachment to the unit</td>
</tr>
<tr>
<td>Experienced</td>
<td>Awareness of only the unit’s needs (versus the entire hospital staffing needs)</td>
</tr>
<tr>
<td>Accountability</td>
<td>Labor intensive **</td>
</tr>
<tr>
<td>Awareness of unit culture</td>
<td>Attachment to unit personnel (have a relationship with staff members)</td>
</tr>
<tr>
<td>Greater knowledge of patient care</td>
<td></td>
</tr>
</tbody>
</table>

* Especially important if there are many longevity employees because these employees have more available benefit time to use

** A decentralized coordinator must stop doing the task at hand to cover an illness call at the last minute. This can consume much valuable time.

**TABLE 5-3: PROS AND CONS OF A CENTRALIZED SCHEDULING COORDINATOR**

<table>
<thead>
<tr>
<th>Pros</th>
<th>Cons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Awareness of external agency staffing pools</td>
<td>Lack of knowledge of specific skill sets of nurses</td>
</tr>
<tr>
<td>Detachment from units</td>
<td>Lack of awareness of unit benefit use</td>
</tr>
<tr>
<td>Experience</td>
<td>Lack of awareness of unit benefit use</td>
</tr>
<tr>
<td>Awareness of internal float pool nurses (knows likes and dislikes)</td>
<td>Less accountability</td>
</tr>
<tr>
<td>Awareness of “house” hospital picture</td>
<td>Lack of awareness of individual unit culture</td>
</tr>
</tbody>
</table>

**RESOURCES**

American Association of Colleges of Nursing  
http://aacn.nche.edu

American Nurses Association  
http://www.nursingworld.org/

Hospital Staffing Issues  

Mandatory Overtime  
http://www.nursingworld.org/MainMenuCategories/Policy-Advocacy/State/Legislative-Agenda-Reports/MandatoryOvertime

HealthLeaders Media  
Patient Classification Systems Address Nurse Staffing Balance  
http://www.healthleadersmedia.com/page-3/TEC-266546/Patient-Classification-Systems-Address-Nurse-Staffing-Balance

**CHAPTER 6: STRATEGIC PLANNING**

**CHAPTER OBJECTIVE**

After completing this chapter, the learner will be able to discuss the importance of strategic planning for healthcare organizations.

**LEARNING OBJECTIVES**

After studying this chapter, the learner will be able to:

1. Define the strategic planning process.
2. Describe the five phases of strategic planning.
3. Recognize the organizational TOWS matrix.
4. Describe the significance of marketing for healthcare organizations.
5. Identify programs that nurses and healthcare organizations can effectively market.

**OVERVIEW**

A strategic plan is a deliberate organization-al document developed to identify, garner consensus about, and communicate the direction in which an organization is going and establish a timeframe for goal attainment (Hader, 2006). In healthcare organizations, goal-based strategic plans are used to determine the future direction
of the organization. Imagine getting into a car in California with a goal of going to Maine and having no road map. Simply put, a strategic plan is a healthcare organization’s map for where it wants to be in the future, with phases providing the direction to reach the destination.

A strategic plan is the outcome of processes through which healthcare organizations engage in environmental analysis, form goals, and develop strategies, with the main purpose of organizational growth (Kelly, 2012). Strategic planning involves developing phases for an organization to accomplish its mission and goals (Swayne, Duncan, & Ginter, 2008).

Healthcare personnel need to understand their organizations’ strategic plans and be active participants in their strategic planning processes. Participation in the planning process may vary according to each person’s position in an organization. The purpose of this chapter is to outline the five phases of the strategic planning process.

### STRATEGIC PLANNING PROCESS

The various members of an organization play different roles in strategic planning. Staff nurses and other frontline health professionals, such as physical therapists and social workers, should be involved in the strategic planning process. These levels of personnel commonly carry out plan strategies; therefore, their opinions and participation are crucial in successful strategic plan implementation. If frontline staff are not members of the strategic planning committee or subcommittees, they should be given reports on strategic planning processes and their input should be solicited. All members of a healthcare organization should be apprised of plan initiatives and have an avenue to express their opinions to facilitate “buy-in” when the time comes to implement the strategic plan. If members choose not to participate, at least their ideas have been solicited and they cannot later say they were not informed of strategic planning processes. Members of the upper-level administration must ensure that personnel resources and budgets are adequate to put the strategic plan into action.

The strategic planning process mirrors the nursing process of assessment, diagnosis, planning, implementation, and evaluation (see Figure 6-1). Strategic planning usually begins because of a recognized need within the organization that requires establishing a competitive advantage in the marketplace (Huber, 2010). The following questions are examples of ones that might be discussed during the beginning phases of the strategic planning process:

- What excellent services or programs do we currently have?
- What new services or programs do we want to obtain in the future?
- What resources will we need to build new services or programs?
- What strategies will we employ to reach our goals?

### TOWS Matrix

In the initial step of the strategic planning process, an assessment of the organization can be done using a tool called the TOWS matrix, which consists of four major components: threats, opportunities, weaknesses and strengths. (See Figure 6-2 for the TOWS analysis framework.) The TOWS matrix is used for systematic analysis that facilitates matching the external threats and opportunities with the internal weaknesses and strengths of an organization (Swayne et al., 2006). This tool enables the members of an organization to brainstorm to address the situation being studied (Kendrick, 2011). Based upon a review of the TOWS matrix, an organization can determine the need to establish a new major program.

The TOWS matrix is similar to the SWOT analysis, which is often used in strategic planning. At a practical level, the only difference between TOWS and SWOT is that TOWS emphasizes the external environment, whereas SWOT emphasizes the internal environment. The TOWS matrix provides information on the healthcare organization’s available resources in a competitive healthcare environment (Kendrick, 2011).

Environmental factors specific to healthcare organizations are classified into the four categories listed here.

- **Threats**: external environmental factors that threaten the healthcare organization
  - a new hospital that opens in a close neighboring community (competition for personnel and patients)
  - new accreditation guidelines that can be labor- and cost-intensive
  - physician specialists with practice privileges in neighboring communities (potential loss of patient base)

- **Opportunities**: external environmental factors that support opportunity for growth
  - large patient cohorts of diagnostic categories (e.g., elderly population in need of gerontologists, patients who have diabetes and would benefit from endocrinologists)
  - new documentation and medication distribution technologies
  - movement of a university into the geographic area (potential recruitment of healthcare and business personnel)
  - loyal personnel who want to grow with the organization.

- **Weaknesses**: absence of strengths and resources
  - dated equipment
  - constant staff turnover
  - lack of physician specialists
  - multiple vacancies for nursing positions
  - high turnover rates
  - negative organizational culture.

- **Strengths**: healthcare organization resources that give a competitive advantage
  - physician specialists
  - specialty operating equipment
  - reputation in the community
  - nursing positions filled
  - experienced healthcare personnel with several years of longevity.

Understanding the TOWS matrix from an organizational perspective is important for the strategic planning process. For example, if the Smith Regional Medical Center (SRMC) plans to open a new comprehensive cardiac care center, they would want to assess the threats, opportunities, weaknesses, and strengths. See Table 6-1 to review a completed TOWS matrix. Based on the information learned by completing the TOWS matrix, the organization decides to open the new comprehensive cardiac care center. The strengths and opportunities identified in the TOWS matrix support that opening a new cardiac center is viable. The SRMC team viewed the strengths and opportunities as outweighing the identified weaknesses and threats to opening the center.

### FIGURE 6-2: TOWS ANALYSIS FRAMEWORK

[Diagram showing the TOWS analysis framework with labels for Environmental Scan, Internal Analysis, and External Analysis.]

Information depicted in the completed TOWS matrix is beneficial in matching the organization’s resources to the competitive healthcare environments in which the organization functions. The diagram above reflects how the TOWS matrix fits into the environmental (internal and external) scan.
TABLE 6-1: TOWS MATRIX TO ASSESS VIABILITY OF OPENING A COMPREHENSIVE CARDIAC CARE CENTER

<table>
<thead>
<tr>
<th>Threats</th>
<th>Opportunities</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Other regional medical centers have greater numbers of cardiac physician specialists</td>
<td>• Smith Regional Medical Center is located in a desirable geographic location</td>
</tr>
<tr>
<td>• Other cardiac care centers within a 2-hour radius of Smith Regional Medical Center (competition)</td>
<td>• Smith Regional Medical Center has a strong marketing plan</td>
</tr>
<tr>
<td>• Other regional medical centers have a strong cadre of allied healthcare professionals (nurses, imaging sciences, surgical technicians) skilled in care delivery for cardiac disorders</td>
<td>• Tuition reimbursement programs for registered nurses (RNs) wanting to pursue advanced degrees that would support the mission of the new comprehensive cardiac center</td>
</tr>
<tr>
<td>Weaknesses</td>
<td>Strengths</td>
</tr>
<tr>
<td>• A need exists for greater numbers of physician specialists in cardiology and cardiovascular and cardiothoracic surgeons</td>
<td>• The Smith Regional Medical Center’s Foundation Board has several benefactors who are willing to make major contributions to open a new comprehensive cardiac care center</td>
</tr>
<tr>
<td>• Shortage of RNs with acute/critical coronary care experience</td>
<td>• Strong Education Department at Smith Regional Medical Center</td>
</tr>
<tr>
<td>• Decreased numbers of allied healthcare professionals skilled in the care delivery for cardiac disorders</td>
<td>• Fiscal reserves within Smith Regional Medical Center can support this additional service</td>
</tr>
<tr>
<td>• 10% vacancy rates for nurses at Smith Regional Medical Center</td>
<td>• Several RNs are pursuing credentials to support this new specialty program: critical care certification, advanced cardiac life support (ACLS) certification, advanced nursing degrees in the critical care/cardiac field</td>
</tr>
<tr>
<td>• Wage package is below regional averages for nursing and allied health staff</td>
<td>• Current technologies are in place</td>
</tr>
</tbody>
</table>

It is important that every member of an organization be involved in this process of assessing the internal and external environments. If an organization has a team of neurosurgeons and neighboring hospitals do not have this resource, the organization must capitalize on this strength. This is an example of an opportunity, because the organization could develop a state-of-the-art rehabilitation center to treat traumatic brain injuries and patients who are recovering from aneurysm repair and other neurological disorders, thus capturing the market for this patient demographic. After the rehabilitation center is developed, an example of a potential threat would be a neighboring hospital that opens a rehabilitation center or unit because both hospitals would be competing for the same patients. Nurses could carry credentialing from the American Nurses Credentialing Center for certification in critical care, neurology, or rehabilitation nursing and go on for advanced degrees in formal collegiate programs, thus adding to the value of the organization through education.

Management should capitalize on an organization’s strengths for future growth and development. If a facility does not have physicians and nurses in a highly specialized area of health, management should focus on the strengths of the people and programs in which the organization excels.

Phase I: Environmental Assessment

Environmental assessment is the initial step in the strategic planning process (Hader, 2006; Kelly, 2012; Swayne et al., 2008). External environmental analysis involves reviewing the residents of the region served, population demographics, and socioeconomic, educational, and political dynamics relative to their impact on opportunities and threats within that environment. All members of an organization can assess their competitors relative to their own competitive advantages.

An environmental assessment also must include the organization’s size, number, and uniqueness of programs; fiscal and personnel resources; technology; and development and research capabilities (Hader, 2006; Kelly, 2012; Swayne et al., 2008; Yoder-Wise, 2011). In other words, organizational team members must ask:

• What are we good at?
• What are our unique programs?
• What diseases and disorders do our physicians specialize in treating?
• What expertise are we recognized for in the community?
• What resources do we have to start new initiatives?

Phase II: Mission Statement, Vision, Philosophy, Goals, and Objectives

Mission Statement

A mission statement reflects an organization’s unique purpose (Hader, 2006; Kelly, 2012; Swayne et al., 2008; Yoder-Wise, 2011). Mission statements need to be more than words, documented and filed away until the Joint Commission visits. All members of an organization, including physicians and board of director members, need to be active participants in defining an organization’s mission and then living the mission in their daily work (Hader, 2006). The mission must be consistent with the values of the individual and the organization. New members should be taught the organization’s mission at, or before, the time of hire. If this has not been accomplished during the hiring process, the organizational mission should be shared at orientation sessions. A clear alignment among the organizational mission, leaders’ actions, and implementation by staff members contributes to a positive work environment and culture. Mission statements are implied at times by the name of the organization. (See Box 6-1 for an example of a mission statement.)

BOX 6-1: SAMPLE MISSION STATEMENT

Julie Jones Women’s Health Center

The mission of the Julie Jones Women’s Health Center is to reduce the incidence of a leading cause of cancer-related deaths in women by delivering cost-effective, comprehensive, preventative breast cancer screening programs to women ages 40 to 70 in the southern region of the United States. The Julie Jones Women’s Health Center is committed to programs that focus on women’s breast health, without consideration for the ability to pay for services, through partnerships with interested constituencies and regional partnerships.

When nurses are unaware of their organizations’ missions, they may have trouble identifying their purpose for practicing in a particular area. The case study in Box 6-2 demonstrates the importance of knowing an organization’s mission and being able to articulate the mission for nurses practicing in specific roles. Equally important is for other team members, including physicians, to be aware of and support the organizational mission.

The core purpose of the organization is relatively unchanged (Huber, 2010). It provides guidance in forming and articulating the organization’s mission.

In the strategic planning process, the facilitator asks multiple questions of the group to stimulate ideas and discussion that can lead to the development of an explicit mission and vision statement (Huber, 2010). Some questions the facilitator may pose are:

• What are our current viable programs?
• What are the healthcare needs of this community?
• What programs do we want to open in the future?
• What services must be provided to meet our consumers’ health care needs?
• What does our customer “look like” (demographics)?
• Who are our current stakeholders?
• Who will be future stakeholders? How will their demands be different?
• Where do we need to focus recruitment efforts?
• Who are our competitors?
• Who will be our future competitors?
• Who are our current partners?
• Who will be potential future partners?
• Are we competitive from a technological standpoint?
• What are our current resources (operating, capital, personnel)?
• What is occurring in the internal and external environment that may affect the organization now and in the future?
Vision Statement

A vision statement is a deliberate and future-oriented statement that describes where an organization hopes to be, based on its core organizational mission (Yoder-Wise, 2011). Vision statements are brief, usually containing only one or two sentences. An example of a vision statement appropriate to the mission described in Box 6-1 would be: “To be the premiere women’s breast health center in the region.” These short vision statements give the consumer a “picture” of what the organization is all about. Therefore, it is important to make every word count in the vision statement.

Philosophy

The philosophy of an organization reflects its core values (Kelly, 2012). A mission statement can provide insight into understanding an organization’s value system. A nurse’s personal philosophy is influenced by what is learned in school and by clinical practice experiences. This philosophy reflects what a nurse values and should complement the philosophy of the unit on which the nurse practices. Understanding the importance of personal and organizational philosophy helps the nurse contribute as a leader and practitioner within a unit in the larger organization.

Goals

The goals of an organization must reflect the critical success and direction of the mission and vision statements (Swayne et al., 2008). Goal setting is a process that formalizes the objectives of the organization. Examples of goals for the organization outlined in Box 6-1 could be to:

- provide comprehensive education on breast health for women in the southern region of the United States.
- develop brochures aimed at teaching breast self-examination.
- establish mammography centers in rural areas of the southern regions of the United States.
- provide interdisciplinary teams of specialty physicians, nurses, psychologists, chaplains, and social workers to interact with and treat women who have a breast cancer diagnosis.

Goals must be specific. They identify the “who,” “what,” and “where” of the specific strategies to be employed (Huber, 2010). Goals tend to convert the abstract mission into concrete statements that are measureable. They are written to reflect what should be versus what is and encourage individuals to reach beyond their current performance statuses and challenge them to increase their productivity. Examples of goal statements written on a patient care unit are:

- Increase the number of baccalaureate-prepared RNs to 80% (needed to achieve Magnet status).
- Increase the number of nurses holding national specialty certification by 50%.
- Increase the number of full-time equivalents by three full-time positions.

Objectives

Objectives are interventions that help attain the overall goals of an organization (Yoder-Wise, 2011). They must be succinct, measurable, and understood by the healthcare team members. Good objectives adhere to the acronym SMART, which stands for:

- specific
- measurable
- achievable
- results oriented
- time bound

Sample objectives for the organization outlined in Box 6-1 could be to:

- promote earlier detection of breast cancer than would occur if screening were unavailable.
- establish protocols and standards of practice for all healthcare professionals affiliated with the program.
- develop affiliations and partnerships to help deliver programs within the region.
- provide screenings for a minimum of 80% of women in the region every 2 years.
- provide ongoing evaluation of the program to include needs of women in the southern region and measure outcome variables.

Phase III: Identification of Strategies

In Phase III of the strategic planning process, all healthcare team members provide input and develop a comprehensive plan to meet the objectives of the organization (Swayne et al., 2008; Yoder-Wise, 2011). In this intervention phase, action plans are developed, budgets are prepared, and departments or units within the hospital develop long- and short-term goals and objectives and allocate resources to meet the organization’s mission. Strategies must be planned and purposeful, yet must be flexible enough to change when unintended events occur (Huber, 2010). An example of an unintended event is when a new opportunity comes to light, which was not known when the strategic plan was developed. Changes in technology and product lines occur frequently, and these occurrences may require a change in the strategic plan; therefore, the planning team members must meet on a regular basis and respond to changes occurring in the healthcare environment.

According to Huber (2010), championing new strategies is accomplished by keeping key members informed about customer and stakeholder needs and how the organization exploits opportunities and responds to changes in the healthcare environment. This impacts organizational growth and how new financial and strategic objectives are formed. Therefore, planned management strategies help the organization maintain its strength in the marketplace and maintain a fiscal competitive edge in its service region. Strategies developed by the organization must address:

- advances in technology (EHR, clinical simulation)
- natural disasters and crises (debilitating hurricanes, tornadoes)
• new opportunities (additional programs, physician specialists to meet demands in a specific service sector)
• changing needs of consumers and stakeholders
• fiscal support
• varying market conditions (changing age demographic, chronic healthcare needs)
• regulatory agency requirements
• fluctuating political environment (demographic changes can adversely affect reimbursement).

Phase IV: Implementation

The implementation phase is the action phase in the strategic planning process. Marketing, budgeting, personnel, and programmatic plans are the focus in this phase of the strategic planning process. Actions and interventions are implemented based on their priorities (Yoder-Wise, 2011).

Research suggests that when staff members are involved in developing future priorities and determining policies, procedures, and protocols to facilitate operationalizing the plan, there is more buy-in to achieving the goals. The organization must have structures in place to ensure the effectiveness and efficiency of implementing new strategies (Huber, 2010). Merit reward structures, positive organizational culture, and availability of resources contribute to the effectiveness of strategy implementation. Implementing strategies are linked to the organization’s usual way of doing business; how it manages on a daily basis, encourages employees, alters organizational culture, practices supervision, and leads the organization (Huber, 2010). In leading strategic initiatives, managers must perform the following roles to ensure staff investment into seeing that strategic plans are operationalized at the bedside:

• Demonstrate support for the implementation of the strategy.
• Publicly acknowledge the positive works of employees who support and implement the strategy.
• Reward employees for successful implementation of the strategy (does not have to be monetary; it could be granting preferences for a certain day off).
• Allocate needed resources for equipment and activities critical to the success of the strategy.
• Possess strong quality management plans.
• Maintain a culture that embraces the ideas and opinions of others who have differing opinions on how best to support the implementation of strategic initiatives.
• Develop policies, procedures, and protocols that support the identified strategy.
• Communicate the strategy implementation plan to staff on all shifts.
• Post the written strategic plan in a public place so all members can view strategies to be implemented, thus facilitating understanding and support for the initiatives.

Phase V: Evaluation

The entire strategic plan must be continually monitored to determine if goals and objectives are being met or if they need to be revised based on environmental factors. It is not a static process. These factors might include:

• legislative cutbacks that negatively impact the budget.
• resignations of key personnel.
• diminished focus of team members.
• lack of commitment (buy-in) because employee was not present when the plan was initiated.
• presence of an appropriate back-up plan, or “Plan B.”
• intactness of the integrity of the organization’s mission.

Through comprehensive evaluation of the strategic plan, future plans can be revised to reflect the current needs of the organization and the community served. Ongoing evaluation of all aspects of the strategic plan is important to ensure quality care delivery.

Strategic Planning Summary

Reviewing the TOWS matrix can help shape future directions. Analysis of the TOWS matrix and revising it to reflect current trends within the organization is necessary to the success of the strategic planning process. Scrutiny of the TOWS matrix analysis leads the organization to develop additional strategies and build upon organizational success. According to Huber (2010) this analysis helps the organization to:

• capitalize on their strengths
• address and minimize weaknesses
• develop opportunities
• avoid threats.

MARKETING

Many hospital organizations market themselves and their programs within the facility and to external constituents. Marketing is defined as analyzing, planning, implementing, and controlling programs to facilitate organizational goal achievement (Yoder-Wise, 2011). Kotler & Armstrong (2008) further explain that marketing involves the social and managerial processes that enable an individual, or group of individuals, to obtain what they want through developing, offering, and exchanging ideas and products that others may value.

Many social programs designed by nurses, such as antismoking initiatives, alcohol and drug awareness programs, and emergency sexual assault programs, are effectively marketed (Konradi & DeBruin, 2003). These programs bring recognition to the facilities and services to the communities. Aligning programs with an organization’s goals is important.

SUMMARY

Involvement of staff at all levels contributes to buy-in and commitment to an organization’s mission. Employees of an organization must learn the mission of the organization during the interview process. Current and future employees must believe in the mission and accept it as the guide for their future activities. Understanding the mission better enables every member of the organization to make valuable contributions to the organization’s success. Strategic planning must involve every person employed by the healthcare organization in some capacity to ensure success and future viability of the organization. Involvement in strategic planning may include being knowledgeable about the process and offering input to the strategic planning team. Staff participation, regardless of their roles in the progression of the strategic plan, is important to the healthcare organization. Answer the self-assessment questions for Chapter 6 at the end of the course.

RESOURCES

Examples of mission statements for healthcare organizations:
Other resources:
SWOT Analysis http://www.quickmba.com/strategy/swot

CHAPTER 7: ORGANIZATIONAL DESIGN STRUCTURES

CHAPTER OBJECTIVE

After completing this chapter, the learner will be able to describe the different organizational structures used in healthcare organizations.

LEARNING OBJECTIVES

After studying this chapter, the learner will be able to:
1. List components of an organizational chart.
2. Differentiate between line and staff positions.
3. Describe different organizational structures, including centralized, decentralized, hybrid, matrix, and shared governance.

OVERVIEW

An organizational chart conveys much information about an organization. Nurses must know how to read an organizational chart to learn how services offered by the organization (such as pharmacy, nursing, information management, and dietary services) relate to each other. The organizational chart provides employees with a picture of work groups and reporting relationships.

The purpose of this chapter is to provide the learner with an understanding of the common organizational structures seen in healthcare organizations. Additionally, line and staff positions will be explained so that nurses can understand the different responsibilities of fellow professionals. Illustrations of the different structures will assist the reader to envision the inner workings of an organization and the nurse’s role within it. Case studies will be employed to assist in understanding different hierarchical structures.

THE HEALTHCARE ORGANIZATION

An organization should be arranged in a way that assists healthcare professionals execute the mission and vision of the organization, formalize their lines of communication, and outline reporting relationships (Kelly, 2012).

SPAN OF CONTROL

The span of control is defined as the number of subordinates one supervisor can effectively manage (Finkelman, 2012). It refers to the number of hierarchical levels under the chief executive officer or
president of an organization. More efficient organizations have a shorter span of control for managers.

Large organizations that have many specialized departments typically have centralized structures for authority and a tall structure with many small work groups. Government-run facilities and large teaching research centers such as St. Jude Children’s Hospital are examples of organizations that have centralized structures. Conversely, small, less complex organizations have flat (shorter) structures in which authority is decentralized, with several supervisors having oversight of larger work groups. Small, rural community hospitals frequently have decentralized structures.

**ORGANIZATIONAL CHART**

The organizational chart is a graphic representation of the different work groups and reporting relationships within an organization. The organizational chart relays the division and differentiation of special labor functions completed by different specialties within the organization (Yoder-Wise, 2011). Divisions, such as nursing, allied health, materials management, and finance, have their individual structures within the organization. In many ways, an organizational chart is like a job description because it gives the nurse a view of role expectations.

Five major aspects of an organization are reflected on the schematic representation of the institution (Hader, 2006; Kelly, 2012; Sullivan & Decker, 2005; Yoder-Wise, 2011). Nurses can learn much about the institution from viewing the organizational chart. For example:

1. Division of work: Each box represents an individual or a work-group cluster for a specific workload.
2. Chain-of-command: Solid lines indicate reporting relationships (line position); split lines represent support positions (staff position).
3. Type of work: The chart is often indicative of the work being performed and individual and group responsibility areas.
4. Delineation of work groups: The chart shows how work is arranged.
5. Depiction of the overall management and administrative hierarchy: This hierarchy is shown through the levels of management.

The organizational chart also identifies the actual or potential flaws of an organization, such as:

- confused lines of authority
- duplicity of roles and functions
- dual reporting structures (seen especially in matrix designs)
- lack of supervision
- gaps in function.

**LINES OF AUTHORITY**

Organizations have two basic types of authority: line and staff. Line authority is depicted as a solid line on an organizational chart. Staff authority is illustrated by a split or dotted line.

**Line Authority**

Line authority is the linear chain-of-command through which tasks are directed (Sullivan & Decker, 2005; Yoder-Wise, 2011). People in line positions are held responsible for achieving the objectives of the unit or department. These positions are essential to producing products of the organization and hold a direct line of hierarchical authority. Registered nurses, licensed practical nurses (LPNs), licensed vocational nurses (LVNs), and unlicensed assistive personnel who have direct care responsibilities are in line positions.

**Staff Authority**

Staff positions are extremely important within an organization because they support line positions (Sullivan & Decker, 2005). Clinical nurse specialists (CNSs), clinical educators, and nurse researchers commonly hold staff positions because they offer advisory support to people in line positions. These support positions are depicted by split lines on an organizational chart. See Box 7-1 for an illustration of support positions on an organizational chart.

**ORGANIZATIONAL STRUCTURES**

Healthcare institutions have several different types of organizational structures. Examples include centralized, decentralized, matrix, and hybrid structures. Shared governance models that are emerging in hospitals to promote autonomous nursing practice are associated with decentralized organizational structures.

**Centralized Structures**

Centralized hierarchal structures are arranged by specialty areas (Yoder-Wise, 2011). This structure type is commonly seen in hospitals and is composed of patient care units, such as the medical floor, surgical floor, and critical care. (See Figure 7-1.)

Many times, departments that perform similar functions (such as caring for patients with certain disorders) report to a common manager who reports to a vice president (in the aforementioned scenario, a nursing vice president). Centralized structures are very tall in that there are many layers between the institution’s board of directors and the lower line positions in the organization. Figure 7-2 depicts a schematic representation of many different departments in a centralized structure. One drawback of this system is that communication sometimes gets lost within the layers of management.

**Decentralized Structures**

Decentralized structures are graphically depicted as flat because, unlike centralized structures, they do not have many different decision-making layers (Hader, 2006; Finkelman, 2012). (See Figure 7-3.) Autonomous decision-making is associated with shared governance practice models. Many hospitals that have Magnet recognition credit their nurses for quality nurse-practice initiatives (Yoder-Wise, 2011). Nurses practicing in shared governance models typically work in decentralized organizational structures. Nurses at the bedside have decision-making knowledge and power that impacts quality of care and positive patient outcomes. Staff nurses collaborate with management to make informed decisions on all aspects of patient care. Nursing staff with the authority to make independent patient care decisions at the point of care is a hallmark of flat, decentralized structures.

Nurses who desire to practice within a decentralized structure that values their input and expertise should ask very specific questions when transferring to a different position within the organization or beginning a new position all together. The answers they receive can reveal whether they would be entering an environment conducive to their expectations for nurse autonomy. Examples of questions to ask include:

- Do nurses on this unit complete self-scheduling?
- Are there nurse governing councils for quality?
- Is evidence-based practice recognized? Is it valued?
- What is the staff nurse role for participation in managing the client care unit?
- Are nurses asked to participate in policy decisions?
- What was the most recent quality initiative spearheaded by a nurse in the unit?

**Matrix Structures**

Matrix structures are seen in large, complex healthcare organizations (Hader, 2006; Hatch & Cunliffe, 2006). These structures are a combination of centralized configurations and multiple project teams. Individuals may report to more than one manager, each with a different style for directing the workforce. This dual line of authority creates a unique environment mired with many challenges. Success is contingent on the staff recognizing and appreciating each of the different product lines and a shared commitment to the mission of the organization. Positive aspects of working within...
Shared Governance

Shared governance is a practice model that values nurse’s autonomous decision making. The focus of shared governance is based on a partnership between staff nurses and nurse managers for addressing and resolving issues and concerns collaboratively (Clark, 2009).

Shared governance involves empowered nurses making patient care decisions and providing quality care at the point of service (Barden, Quinn-Griffin, Donahue, & Fitzpatrick, 2011; Porter-O’Grady, Hawkins, & Parker, 1997). Knowledge is shared through nurse councils working on different issues and needs of the patient care unit. These councils may be selected by the staff and manager to deal with special issues and tasks. Examples of different councils are:

- Nurse Practice
- Quality Improvement
- Policy Initiatives
- Evidence-Based Practice
- Staff Development

Highly functioning shared governance structures have actively participating professional nurses who value responsibility and authority and are accountable for the decisions made in practice (Huber, 2010).

Shared governance is an active process that changes when new nurses are hired and as healthcare and organizations experience change. Moore and Hutchinson (2007) state that nurses who are new to shared governance need to be accepted for where they are in their careers and mentored to progress to the next point in their professional roles.

Staff development and formal educational programs need to be available to nurses in hospitals that support a highly functioning shared governance model (Huber, 2010; Moore & Hutchinson, 2007). Educational programs should include:

- Developing leader behaviors and skills
- Consensus building
- Conflict resolution
- Communication skills
- Running effective meetings
- Data management
- Problem solving

Nurse managers who function effectively in a shared governance structure are willing to surrender control to facilitate developing and building leaders; however, they may find that their time will be spent in mentoring and coaching staff nurses (Huber, 2010). Responsibility for patient care and outcomes of care delivery rest with the entire nursing unit team versus the nurse manager. The effective nurse manager who supports the shared governance model builds trust and respect among team members in an environment where care of the patient is the central focus for the entire healthcare team.

Research done by Barden and her colleagues (2011) supported a positive relationship between empowerment and shared governance. Nurses practicing on units using a shared governance model reported increased access of information, support for trying new quality systems, and greater availability of resources. Additionally, nurses reported greater job satisfaction, job retention, and increased productivity.

Box 7-2 looks at the roles of a nurse manager and a clinical educator. Both positions are important to maintain seamless workflow in a healthcare organization. The case study in Box 7-4 reviews how a nurse practitioner-run clinic uses line and staff positions to operate a for-profit family practice.

SUMMARY

Organizational designs reflect how work is done and how outcomes are accomplished in organizations. Nurses who are highly skilled, have advanced educations, or have many years of nursing experience may be frustrated if they practice within a highly centralized organizational structure. An organizational chart can reveal a lot about an individual organization. Nurses knowledgeable about organizational design can select a unit or division within an organization that is consistent with their personal philosophy of nursing practice.

Some exercises the learner may want to consider include:

- Look at your own institution’s organizational chart. What is your institution’s organizational design?
- Explore the web for large, teaching and research healthcare organizations and view their organizational structures. Do the same for community hospitals. What impressions do you have about these organizations relative to their stated mission and vision statements and their organizational designs?
- Answers to these questions can help nurses determine in what type of organizational structures they want to practice. Satisfaction with their positions and units of employment can facilitate nurses thriving in their practice settings.

Answer the self-assessment questions for Chapter 7 at the end of the course.

RESOURCES

Basic Organizational Chart
FIGURE 7-2: CENTRALIZED ORGANIZATIONAL STRUCTURE

Board of Directors

Chairman of the Board

Chief Executive Officer

Chief Operating Officer

Vice President of Finance
- Accounting Manager
- Business Director
- Personnel Director
- Risk management team

Vice President of Nursing
- Director of Medical Units
  - Nurse managers
- Director of Critical Care Service
  - Nurse managers
- Director of Surgical Units
  - Nurse managers
- Director of Walk-in Clinics
  - Nurse managers
- Director of Home Health
  - Nurse managers

Vice President of Allied Health
- Director of Laboratories
  - Laboratory managers
- Director of Medical Records
  - Manager of Medical Records
- Director of Pharmacy
  - Manager of Pharmacy
- Director of Nuclear Medicine
  - Manager of Nuclear Medicine

Vice President of Materials
- Director of Materials Management
- Manager of Medical Records
- Manager of Purchasing
- Director of Plant Management
- Manager of Engineering
- Manager of Group Services
- Manager of Housekeeping

FIGURE 7-3: DECENTRALIZED ORGANIZATIONAL STRUCTURE

Vice President of Client Care Services

Pharmacy Director
- Staff Pharmacists

Operating Room Director
- Staff Nurses

Critical Care Director
- Staff Nurses
BOX 7-2: CASE STUDY – LINE AND STAFF POSITIONS

Dianne is a nurse manager for a large general surgical unit at a local community hospital. Many local physicians schedule their patients for operative procedures in this hospital because the operating room schedule is flexible and the nursing care on the surgical unit is excellent. The occupancy rate for the 50-bed surgical unit, which has a position control of 60 FTEs and employs approximately 67 nurses, is close to 100%.

Janelle is the clinical educator assigned to the surgical unit. She works on all surgery-related units and is a clinical nurse specialist whose focus is surgical nursing. Dianne and Janelle work well together as a team and establish annual goals. They meet monthly to assess their progress. Dianne is responsible for budget finance and human resource management, and Janelle is responsible for new employee orientation and staff nurse development.

Discussion Questions
1. Is Dianne in a line or staff position? Is Janelle in a line or staff position? What are the differences between line and staff positions?
2. For what tasks is Dianne held accountable? For what tasks is Janelle held accountable?
3. Who has the authority to make decisions for the surgical unit?
4. What resources can Dianne and Janelle consult to determine their levels of accountability?

See Box 7-3 for answers to these questions.

BOX 7-3: ANSWERS TO CASE STUDY – LINE AND STAFF POSITIONS

1. Dianne is in a line position. Janelle is in a staff position. People in line positions are held responsible for achieving the objectives of the unit or department. People in staff positions assist those in line positions in achieving unit or department goals. These personnel serve as educators, advisors, and consultants.
2. Dianne is responsible for all budget aspects of managing the surgical unit and all personnel decisions. Janelle is responsible for all new employee orientation and staff development for nurses employed on the surgical unit.
3. Because Dianne is a nurse manager, she has the authority to make decisions for the unit.
4. Resources include the organizational chart, job descriptions, and a nurse executive.

BOX 7-4: CASE STUDY – NURSE-MANAGED CLINIC

Patrick is a family nurse practitioner (FNP) who is the director of an independently nurse-run primary care clinic. Two other nurse practitioners also practice in this office. Their caseload has increased significantly and they are looking to hire another nurse practitioner. Patrick recently interviewed a new master’s-prepared FNP. The nurse practitioners manage their own caseloads, work on a rotational call schedule, and consult with the other nurse practitioners in the facility. All practitioners seek advice from a full-time physician who specializes in family practice. The staff meets regularly to discuss patient care issues, workloads, call schedules, productivity, and profit-making strategies. The practitioners have autonomy and can develop patient protocols, assemble patient-teaching materials, and schedule patients per their preferences of work days and times.

Patrick employs two receptionists (who answer the telephone and schedule patient appointments), one X-ray technician, and three LPNs.

Discussion Questions
1. What type of organizational structure is described?
2. Is this a tall or flat structure?
3. Which employees are in line positions?
4. Which employees are in staff positions?
5. What would the clinic’s organizational chart look like?

See Box 7-5 for answers to these questions.
**Chapter 8: Building Cohesive Teams**

**Chapter Objective**
After completing this chapter, the learner will be able to outline strategies to build cohesive teams for healthcare organizations.

**Learning Objectives**
After studying this chapter, the learner will be able to:
1. Differentiate between the concepts of team and group.
2. Identify qualities of an effective team member.
3. Describe dysfunctional group patterns.
4. Define the concept of shared governance.
5. Identify strategies for managing effective meetings.

**Overview**
This chapter explains the major concepts of working effectively as a group or within teams in an organization. In health care, a variety of people work together with the unifying purpose of delivering quality patient care. Team members have varying education and experience backgrounds (e.g., physicians, nurses, social workers, therapists, administrators, and support personnel, such as dietary aids, pharmacy technicians, and maintenance workers). Each team member has an important role and should be treated with respect by others on the healthcare team.

Collaboration among healthcare professionals is recognized as an important link to quality care and a necessary part of reaching positive outcomes in patient care. A basic understanding of teams is necessary for the nurse leader to know how to facilitate individuals from various specialties and backgrounds working together effectively to accomplish a common goal. The difference between groups and teams in healthcare organizations is discussed in this chapter, and the qualities of highly functioning groups and characteristics of effective team members are reviewed. Dysfunctional group patterns are analyzed, and interventions to prevent ineffective group dynamics are examined. The concept of shared governance, which is an organizational structure that empowers clinical nurses to be active participants in determining nursing practice standards and quality of care, is also discussed in this chapter. Case studies are employed for the reader to apply newly learned concepts and to work through difficult situations that may occur when working in groups and on healthcare teams.

**Groups and Teams**
A group is defined as a cluster of people who practice in critical care units, professional nursing organizations, and all members of a specific church. In the example of “older than 65 years of age,” a unified purpose is seen through Erikson’s model of personality development that places members of this group as part of the late adulthood stage known as “Integrity vs. Despair.” In this stage, a common, or unified, purpose of looking back at life and having wisdom is a commonality. Although members of this group have similarities, they are not all working toward a common goal. This distinguishes them from a team.

A team is an assembly of people who are connected by their particular job, work activity, or recreational endeavors (Yoder-Wise, 2011). An example of a team is men on a college basketball team; however, the fact that the group of men wears a common uniform and are ready to play basketball does not make them a team. A team must have similar or complementary skills and be committed to a common purpose. In this example, the purpose might be winning the game. In health care, surgical teams and cardiac catheterization teams are a couple of examples of people working together for the common purpose of caring for patients with a particular health problem. By definition, not every group is a team.

Characteristics of effective team members include having a definite purpose, excellent communication and listening skills, focus on goals, ability to manage disagreements in an open and respectful way, and respect for others’ opinions (Kelly, 2012; McDonald & McCallin, 2010). Effective teams possess a clear purpose and goal, and each member has an understanding of each other’s role in achieving the team objective (Bennett, Perry, & Lapworth, 2010).

The seminal work of Tappen (1995) outlines the advantages of working on highly functioning teams. Tappen identified the following concepts as the major advantages of teamwork:
- Best use of skills: Each person brings a unique skill set, experience, and credentials to a situation. The correct mix of people can manage complex problems and bring about positive patient outcomes.
- Coordination: Coordinating efforts reduces duplication and enhances team productivity.
- Synergy: Working together in a synergistic way stimulates team members and contributes to quality outcomes.
- Flexibility: Team members can cover for each other in emergency situations. Their combination of abilities facilitates handling a greater variety of circumstances.
- Support: Highly functioning teams support each other through high-stress times. Additionally, effective teams have power and can provide political support to each other.
- Increased commitment: When team members have input into goals and objectives for achieving outcomes, they have greater buy-in and commitment to see a task through to successful completion.
- Feedback: Feedback is valued and seen as helpful when provided by a respected team member.
- Opportunity for growth: Effective teams get noticed and are often sought after for input or participation on more-complex projects. Their members are viewed as future potential leaders within the organization.

**Informal Groups and Teams**
Informal groups and teams are an important consideration. They may be planned and authorized or occur spontaneously within the workforce. Either way, the nursing leader should recognize that the importance of such teams has been established for many years (Shortell and Kaluzny, 2006). The influence of an informal team may be positive, with the group acting to facilitate change and improve patient care. However, the nature of informality may lead to more detriment than good, especially if the team’s concerns are not aligned with the organization’s goals. An example of this is an organization that is changing to a new material management system to prevent lost charges and waste, which will result in decreased healthcare costs. Change frequently is met
by resistance; however, if an informal team exists that promotes a negative image of the new system, implementing the change is much more difficult. Kelly (2012) asserts that an informal group may become overly exclusive and create conflict among the staff. The group may become powerful enough to undermine the structure of the organization.

**Dysfunctional Groups**

Highly functioning groups can achieve many goals. However, dysfunctional group patterns can interfere with attaining quality outcomes for staff, healthcare professionals, and patients. Examples of dysfunctional group patterns are social loafing, polarization, groupthink, and scapegoating. Table 8-1 shows actions that leaders can take to overcome dysfunctional group patterns.

**Social Loafing**

Social loafing is seen as the least harmful of the four dysfunctional group patterns. Social loafing can occur in small groups when people do not feel responsible for the task at hand. This usually happens when personnel are not being evaluated for task completion. Working in a small group has many positive aspects, including the positive synergy that occurs when people work together. Shared energy and enthusiasm among a group of nurses working together on a common issue of concern can generate increased productivity. Responsibility for addressing the issue is shared among all group members. The downside to working in a small group is that it may reduce the responsibility each individual feels for task completion, thereby making it difficult for the manager to identify the individual responsible for incomplete work.

**Polarization**

Polarization occurs when a group makes a decision that is more extreme than the initial opinion of its members. In this dysfunctional pattern, some group members are easily influenced by more-dominant group members into supporting their opinions. This behavior is not problematic when deciding whether to go to the hospital cafeteria for lunch; however, it can be harmful when making patient care decisions.

Polarization can occur when a group becomes incensed by a particular issue. An example of polarization is when staff nurses are upset with a management decision to go from 8-hour shifts to 12-hour shifts. One nurse suggests that she will call in sick the next day to protest. The following day, several staff nurses call off of their scheduled shifts.

**Groupthink**

Reaching a consensus involves valuing the divergent opinions of group members and reaching a final conclusion that is supported by the whole. However, a good leader works to avoid the phenomenon of groupthink. The concept of groupthink occurs when the desire for harmony and consensus overrides members’ rational efforts to appraise the situation (Kelly, 2012). Groupthink discourages open discourse and places a higher concern on maintaining harmony, or a pleasant atmosphere, which impedes reaching a good decision (Shortell & Kaluzny, 2006). Nurses with dissimilar opinions keep to themselves in an effort to avoid conflict and support the leader and team members. This behavior is not a healthy communication process and does not lead to the best possible patient outcomes. See Box 8-1 for a case study on how to manage groupthink. Answers are provided in Box 8-2.

**Scapegoating**

A common tendency is to unofficially assign blame within a group. There may be a comedian, the group gossip, or an organizer. Many of these roles emerge based on the individual’s natural skills and attributes; however, this can turn into a negative situation. Scapegoating is the cruelest dysfunctional group pattern. In this pattern, an individual or assembly is singled out for blame, anger, and hostility through inappropriate accusations (Crosby, 2003). The target is a victim of misplaced vilification, hostility, and criticism. It may occur insidiously, without the group intending for it to happen.

An example of this is the group member whose role is to voice frustrations and complaints on behalf of the group. In the beginning, members may encourage the behavior. However, should the group begin to criticize the negative behavior, the responsibility for it may be shifted to the individual identified as the scapegoat.

Another potential cause of scapegoating occurs when a group is frustrated and feels helpless about finding resolution. Especially if the situation is stressful, group members may transfer the negative feelings to one person. The group begins to believe that their inability to obtain a solution is the fault of that one person. The most frequent consequence is that the scapegoat is ejected from the group; this, of course, has a negative impact on the person ostracized. In addition, guilt feelings by other team members accompany the sacrifice of a scapegoat, and the emotional struggles can leave those involved unable to effectively engage in constructive work. Effective leaders must intervene when they see this pattern occurring in health care.

**Successful Teams**

Successful teams require careful planning because teamwork can be advantageous or disadvantageous. When building a team for a project, an initial plan is made to recruit team members, and each individual’s areas of expertise, strengths, and weaknesses are identified. The development of a successful team begins by the nurse leader choosing individuals who bring a variety of expertise and strength to the team and the project that the team will work on. The nurse leader who carefully selects team members with various skills and backgrounds, provides a clear purpose for the team, defines or facilitates the team and each member’s role, and encourages close communication, is setting the stage for an effective team. Facilitating these values is essential to creating an effective and successful team (DiMichele & Gafney, 2005). Prior to beginning the project, the nurse leader should then assess the team’s strengths and weaknesses and identify any gaps in team expertise so that a plan may be formulated to address potential weaknesses.

Steps should be taken to build trust among team members by recognizing each individual’s areas of expertise and promoting a positive atmosphere. Strong team members working together create synergy and produce extraordinary results that could not be achieved by any one individual (Yoder-Wise, 2011). A clear vision must be communicated so that all team members understand the team’s purpose and share the desire to accomplish the team’s goals. Communication must be honest, open, and encourage creativity. These values are essential to creating an effective and successful team (DiMichele & Gafney, 2005). Dualism, which is an either/or way of viewing things, should be discouraged to expand possibilities or “thinking outside the box.” Teams that promote only two options, rather than allowing for open discussion and alternative pathways, find this to be a barrier to effective team function. In addition, team members who would like to share an

---

**TABLE 8-1: LEADER INTERVENTIONS FOR DYSFUNCTIONAL GROUP PATTERNS**

<table>
<thead>
<tr>
<th>Dysfunctional Group Pattern</th>
<th>Leader Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social loafing</td>
<td>• Appoint a chairperson.</td>
</tr>
<tr>
<td></td>
<td>• Call or e-mail the chairperson or group leader to see if he or she has questions.</td>
</tr>
<tr>
<td></td>
<td>• Follow-up halfway through the project to assess progress.</td>
</tr>
<tr>
<td></td>
<td>• Set a deadline.</td>
</tr>
<tr>
<td></td>
<td>• Publicly acknowledge the work of the chairperson and group members.</td>
</tr>
<tr>
<td>Polarization</td>
<td>• Promote an open collegial environment.</td>
</tr>
<tr>
<td></td>
<td>• Encourage open dialogue.</td>
</tr>
<tr>
<td></td>
<td>• Encourage expression of divergent opinions.</td>
</tr>
<tr>
<td></td>
<td>• Encourage critical thinking.</td>
</tr>
<tr>
<td>Groupthink</td>
<td>• Same as polarization with the following additions:</td>
</tr>
<tr>
<td></td>
<td>• Foster and praise independent thinking.</td>
</tr>
<tr>
<td></td>
<td>• Gather data.</td>
</tr>
<tr>
<td></td>
<td>• Give the group time to think about the new data (information) they have collected.</td>
</tr>
<tr>
<td>Scapegoating</td>
<td>Same as group think.</td>
</tr>
</tbody>
</table>

Leaders must promote open communication among all healthcare professionals. They can point out individual behaviors that are not appropriate or helpful away from the group. Finally, they should support all team members for their contributions in the practice environment.
innovative idea may feel undervalued and come to feel that the team is a “waste of time and energy.”

TEAMWORK IN NURSING EQUALIZES POWER BY ALLOWING ALL TEAM MEMBERS TO HAVE A VOICE. IT IS IMPORTANT TO CREATE AN ENVIRONMENT WHERE ALL TEAM MEMBERS FEEL COMFORTABLE SHARING THEIR OPINIONS AND FEEDBACK. TEAMWORK ALSO PROMOTES TEAMWORK IN NURSING EQUALIZES POWER BY ALLOWING ALL TEAM MEMBERS TO HAVE A VOICE. IT IS IMPORTANT TO CREATE AN ENVIRONMENT WHERE ALL TEAM MEMBERS FEEL COMFORTABLE SHARING THEIR OPINIONS AND FEEDBACK. TEAMWORK ALSO PROMOTES

BOX 8-1: CASE STUDY – PREVENTING GROUPTHINK

A 21-year-old man diagnosed with cystic fibrosis is at the end of his life and is being mechanically ventilated. The patient verbalizes, “I want to live as long as God keeps me here.” His primary nurse is aware of this desire. Later in the week, the patient is semiconscious when his family comes to visit. The unit manager, other nurses on duty, and the respiratory therapist (RT) agree that nothing can be done for the patient and he is suffering. The family is unaware of the wishes they expressed earlier in the week. The unit manager, some staff nurses, and the RT ask the family to consider removing the patient from life support. After speaking with all family members, the spokesperson for the family announces that the family is in agreement with removal of all life support. The patient’s primary nurse is present and says nothing. The patient is now fully comatose.

Discussion Questions
1. What dysfunctional group pattern has occurred?
2. What should a nurse leader do to prevent this dysfunctional group pattern? Name some strategies that can be employed to prevent this event from recurring.
3. Which healthcare team members can intervene to prevent this dysfunctional pattern of group behavior?

See Box 8-2 for answers to these questions.

BOX 8-2: ANSWERS TO CASE STUDY – PREVENTING GROUPTHINK

1. The dysfunctional group pattern of groupthink has occurred.
2. Prevention is the best intervention. To prevent this pattern from recurring, the nurse leader can employ the following strategies:
   a. Promote an open collegial environment.
   b. Support nurses to voice divergent opinions, and praise them when they do so.
   c. Encourage nurses to express whatever they are thinking; independent thinking establishes group trust.
   d. Encourage critical thinking.
   e. Allow the group time to gather additional information and then reflect on that new information.
3. Any group member, healthcare professional, or staff member of an organization must convey when he or she sees dysfunctional group patterns. Any person who has knowledge of a groupthink-type behavior is obligated to bring the issue to the forefront and to alert leaders within the organization. In this case study, the primary nurse has an obligation to inform the other members of the group of the patient’s wishes. There are circumstances, however, where the issue is less clear, and precautions should be taken to examine whether the issue is groupthink or merely group agreement on an issue.

innovative idea may feel undervalued and come to feel that the team is a “waste of time and energy.”

TEAMWORK IN NURSING EQUALIZES POWER BY ALLOWING ALL TEAM MEMBERS TO HAVE A VOICE. IT IS IMPORTANT TO CREATE AN ENVIRONMENT WHERE ALL TEAM MEMBERS FEEL COMFORTABLE SHARING THEIR OPINIONS AND FEEDBACK. TEAMWORK ALSO PROMOTES TEAMWORK IN NURSING EQUALIZES POWER BY ALLOWING ALL TEAM MEMBERS TO HAVE A VOICE. IT IS IMPORTANT TO CREATE AN ENVIRONMENT WHERE ALL TEAM MEMBERS FEEL COMFORTABLE SHARING THEIR OPINIONS AND FEEDBACK. TEAMWORK ALSO PROMOTES

Multidisciplinary or Interdisciplinary Teams

Many different types of teams are formed in health care. Multidisciplinary or interdisciplinary teams involve different specialists, such as nurses, doctors, social workers, dieticians, and others, working together toward a common goal. Successful teamwork occurs when multiple healthcare providers work together with the patient, family, or other caregivers to optimize the patient’s care (McDonald & McCallin, 2010). These teams may be created for a single purpose or work together permanently toward a specific goal (Riley, 2009). The commonalities of a successful team include:

- a definite purpose
- members with varied backgrounds and skillsets
- members who communicate frequently and completely
- each member understanding every other member’s role.

Committees

Committees are teams that work on specific projects or goals. They may be broad, such as a committee that reviews and revises nursing policy for the entire organization. This type of committee is known as a standing committee because it meets regularly and continues indefinitely. Other standing committees may be an ethics committee, safety committee, or continuous quality improvement committee.

A committee with a more specific charge is called an ad hoc committee and may be formed to address a very specific problem or issue. For example, when a clinical problem is identified such as an unusually high rate of infections at intravenous catheter sites, an ad hoc committee may be formed to investigate current evidence-based standards of care for intravenous lines, review the current policy and procedure for care of intravenous lines, and determine whether there are barriers to maintaining the standards of care.

A committee may act only in an advisory capacity by reviewing information pertinent to the objectives and offering advice. The committee may not have the authority to change policies or procedures, but it can be very instrumental in influencing the outcome of decisions made by those in positions of authority.

FACILITATING TEAM DECISION MAKING

REACHING A CONSSENSUS WITHIN A TEAM IS OFTEN A CHALLENGING TASK THAT BEGINS WITH INDIVIDUALS REACHING THEIR OWN CONCLUSIONS, AND THEN NEGOTIATING WITH OTHER TEAM MEMBERS. NURSE LEADERS MAY ENHANCE COHERENT TEAM DECISION MAKING BY UNDERSTANDING WHAT INFLUENCES DECISION MAKING AND CRITICAL THINKING AND IMPLEMENTING OPPORTUNITIES FOR TEAM MEMBERS TO PRACTICE THESE SKILLS.

Although a strong knowledge and evidence base supports nursing decisions and actions, experience is also necessary for clinical judgment (Benner, Tanner, & Chesla, 2009). Clinical decision making combines knowledge and practical experiences regarding patient care (Roche, 2002). Characteristics associated with decision making include being assertive, knowledgeable, observant, resourceful, intuitive, and creative (Toofany, 2008). A lack of good clinical decision-making skills or poor recognition of evolving medical emergencies may lead to adverse patient outcomes and is termed failure to rescue (del Bueno, 2005).

Recognizing that teams need both knowledge and experience to facilitate decision making, the nurse leader should plan educational opportunities to strengthen these skills. Innovative educational strategies aimed at developing decision-making skills may enhance each individual member’s decision-making abilities and facilitate team decision making. For example, various forms of simulation are being used to enhance critical thinking skills.

It is helpful to understand some basic principles of adult learning theory. Nurses are self-directed and self-motivated adult learners who are best able to integrate knowledge through active learning methods (Royse & Newton, 2007). Many adults are immersed in technology and expect education to include strategies that are interactive, contemporary, and simulate real experiences (Cangelosi & Whitt, 2005). Three methods that are useful for increasing critical thinking and decision making are case studies, autonomous single-user simulation, and high-fidelity simulation. The learner is referred to Table 8-2 to learn how to enhance critical-thinking and decision-making abilities when working with teams. The nurse leader should be familiar with some basic teaching strategies in order to plan effective team member development.

Case studies are patient scenarios presented with subsequent questions for the nurse to answer. They may be completed individually, with the team coming together afterward to compare and contrast their answers, or completed as a team exercise. The nurse leader should make sure that the experience is positive and that all discussions are respectful and thoughtful. Evidence-based practice should drive considerations for nursing actions and should be stressed during discussion. An appropriate response to a difficult case study might be for a team member to offer to research the most current evidence.

The use of computer-based games to provide interactive learning opportunities is increasing and may offer a popular method of ongoing nursing staff education (Rayfield & Manning, 2009).
Simulation-based games provide instantaneous response, interactivity, challenges, and motivation, and may be particularly appealing to the younger generation who have always had technology readily at hand (Sauvé, Renaud, Kaufman, & Marquis, 2007). In a virtual reality learning environment, educators may provide experiential learning opportunities that, through active participation, facilitate problem-solving and clinical decision-making about the patient’s care during an emergency situation (Kilmon, Brown, Ghosh, & Mikitiuk, 2010; Royse & Newton, 2007). This same approach may be used to facilitate building team decision-making skills through experiential learning in virtual settings, which allow the learner to incorporate knowledge, skills, and reasoning abilities in meaningful ways (Dietzler, 2009). Students have the opportunity to choose priority nursing interventions, with immediate feedback of patient outcomes. The use of autonomous simulation as an educational resource may facilitate nurses’ abilities to form their own judgments, synthesize and apply knowledge in various contexts, and approach professional practice from a reflective, critical, and evidence base.

**TABLE 8-2: STRATEGIES FOR ENHANCING CRITICAL THINKING AND DECISION MAKING AMONG TEAM MEMBERS**

| Case Study | An example of a specific real-life situation or imagined scenario that is used as a training tool. Individuals or teams are asked to analyze the prescribed cases and present their interpretations or nursing actions, which are supported by evidence-based practice guidelines. |
| Autonomous Single-user Computer Simulation | A computer-based program in which individual players interact in simulated patient scenarios to determine the best choices for care. Although autonomous, teams may play together, with one player controlling the program. |
| Low/High Fidelity Simulation | A clinical simulation-based program used by nurses to determine best practices, prioritization, and triage scenarios. Team communication contributes to clinical decision making and augments critical thinking. |

Credentialing Center for attributes of excellence in delivery of premiere quality nursing care.

Shared governance empowers practicing nurses by placing the responsibility, authority, and accountability for nurse practice issues with this professional group. Research supports that shared governance models enhance quality care and result in improved outcomes for patients (Zuzelo et al., 2006).

**TeamSTEPPS**

The Department of Defense’s Patient Safety Program, in collaboration with the Agency for Healthcare Research and Quality, developed a system specifically designed for healthcare professionals known as TeamSTEPPS. The goal of TeamSTEPPS is to improve patient safety within an organization through improved communication and teamwork skills among healthcare professionals. TeamSTEPPS provides evidence-based educational materials in a toolbox that is ready for implementation. The learner is referred to Box 8-3 to learn about materials available in the TeamSTEPPS toolbox.

TeamSTEPPS stresses teamwork and communication among all healthcare personnel, including physicians and nurses, to increase patient safety (Ferguson, 2008). Characteristics of such teams include the ability to use pertinent information, people, and resources to achieve the best clinical outcomes for patients. TeamSTEPPS seeks to increase team awareness by clarifying team roles and responsibilities. An example would be a nurse actively assessing coworkers (in a respectful manner) in anticipation of safety concerns. Consider Nurse A, who observes that Nurse B has a patient crisis causing a work overload and recognizes that medications or treatments for Nurse B’s other patients may be delayed. Nurse A intervenes to help with the workload, perhaps requesting others to help as well. The overall result is that the team works together to provide consistent quality care to all patients.

**Situation-Background-Assessment-Recommendation**

Communication is enhanced by resolving conflicts and improving information sharing using proven effective tools such as Situation-Background-Assessment-Recommendation (SBAR), which is a technique that enhances communication between members of the healthcare team about a patient's condition. SBAR provides a framework that organizes data in a focused manner. Consistent, complete transfer of information, especially in highly critical situations, is essential for developing teamwork and increasing patient safety. The learner is referred to Box 8-4 to learn effective strategies when communicating with physician team members. Successful use of the SBAR system removes barriers to quality and safety in the patient care environment.

**Active Listening**

Active listening is a technique that all leaders should practice and promote for all of their employees. Team members must participate in receiving information as well as in providing it. Active listening involves staying focused on the speaker and listening without judgment in order to gain true understanding of what is being communicated. Successful active listening should result in the listener being able to repeat at least 95% of the intended meaning. Are you an active listener? Reflect on your listening skills; do you sometimes drift in your thinking while another is talking?

**QUALITY AND SAFETY EDUCATION FOR NURSES**

Funded by the Robert Wood Johnson Foundation, the Quality and Safety Education for Nurses (QSEN) project seeks to prepare future nurses with the knowledge, skills, and attitudes (KSA) necessary to continuously improve the quality and safety of the healthcare systems in which they work (Quality and Safety Education for Nurses [QSEN], n.d.b). Through nursing research, six major competencies are identified by QSEN:

- Patient-centered care
- Teamwork and collaboration
- Evidence-based practice
- Quality improvement
- Informatics
- Safety

Building on these competencies, specific attributes are stated for each of the defined competencies to guide student learning and promote widespread acceptance of the standards. The QSEN competencies and KSA’s are available on an open access website (QSEN, n.d.a).

**MANAGING TEAM MEETINGS**

Nurses assigned to patient care units usually meet on a monthly basis, but no less than quart-
**SUMMARY**

Healthy group dynamics in the workplace are essential for effective management of patient care and colleague relations. This chapter reviewed the different types of groups and teams; dysfunctional group dynamics of social loafing, polarization, groupthink, and scapegoating; and successful teams and committees. Models for building collaboration, such as shared governance, TeamSTEPPS, and QSEN, were presented and the positive results of practicing within these management systems were examined. The nurse leader is encouraged to inspire workers toward a commitment of excellence in patient care. Positive attitudes that shift away from fixing blame, to fixing the problem, are stressed for improved patient safety. Acknowledgment or recognition (verbally or written) that an employee is valued and respected are positive actions of a good leader. Effective communication, a key ingredient within teams, was discussed, with the SBAR model presented as an example of a way to improve communication.

**Answer the self-assessment questions for Chapter 8 at the end of the course.**

**Resources**

**Meeting Management:**

**Team Building:**

**Quality Safety Education for Nurses:**
- [http://www.qsen.org](http://www.qsen.org)

**QSEN competencies and KSAs:**
- [http://qsen.dreamhosters.com/competencies](http://qsen.dreamhosters.com/competencies)

**Chapter 9: Patient-Centered Care**

**Chapter Objective**

After completing this chapter, the learner will be able to discuss the concepts of patient-centered care within the contexts of nursing and nursing management.

**Learning Objectives**

After completing this chapter, the learner will be able to:
1. Differentiate between the various definitions of patient-centered care.
2. Describe how nurse leaders can empower nurses to practice patient-centered care.
3. Identify strategies for nurses to empower patients.
4. Discuss patient and nurse communication skills that can enhance patient-centered care.
5. Explain how technology can influence patient-centered care.

**Overview**

Patient-centered care is a relatively recent model of health care that promotes respect for patient preferences, an appreciation of the whole person as...
A nurse manager has called a special meeting to discuss going from 8-hour shifts to 12-hour shifts. The manager is recommending this change for the summer months of June, July, and August. The manager posted the action agenda 10 days prior to the scheduled meeting time. The item will be addressed and the members will vote on whether to adopt the change to 12-hour shifts for the three summer months.

The manager calls the meeting to order and repeats the agenda item to be discussed and voted upon. Before she can get a complete sentence out, Jane, a staff nurse on the 7:00 a.m. to 3:30 p.m. shift, states that she cannot possibly go to 12-hour shifts because it would be inconvenient for her family life. When the manager resumes the initial message, Jane interrupts again and goes into other reasons why this change would not be good. Other team members are becoming frustrated because the nurse manager has not given complete information about the change to the group and none of them have been able to participate in the meeting.

**Discussion Questions**
1. Should the nurse manager intervene when Jane interrupts?
2. What strategies can the nurse manager employ to involve other team members in the discussion?
3. How should the nurse manager handle Jane’s interruptions?
4. If Jane persists in dominating the conversation, what can the nurse manager do?

See Box 8-6 for answers to these questions.

---

**PATIENT-CENTERED CARE: DEFINITIONS**

Until the 1960s, the healthcare system in the United States was based on a paternalistic model, in which the physician was in total control of the patient’s care and the patient was dependent on the physician to make all healthcare decisions. The patient trusted the doctor and did not question the physician’s level of knowledge, skills, morals, or ethics. During this time, medicine focused care on the patient’s symptoms and curing those symptoms. Over the last 50 years, great advancements have been made in medicine and in caring for patients. Power has shifted from physician-centered, biomedical healthcare models to being centered on the patient having a more active role in his or her care (Reynolds, 2009).

The Institute for Patient- and Family-Centered Care (IPFCC; n.d.) is an organization that provides information and leadership in patient- and family-centered care. Their Website includes four core concepts as being basic components of patient- and family-centered care:

- **Respect and Dignity.** Healthcare providers actively listen to patient and family viewpoints and honor their choices. The plan and delivery of health care includes the patient’s and family’s cultural background, knowledge, beliefs, and values.
- **Information Sharing.** Unbiased information is shared with the patient and family in ways that encourage empowered choices. Timely and accurate information is shared with the patient and family to enable participation and decision making regarding care.
- **Participation.** The patient and family are supported and encouraged to participate in care and decision making at the level they choose.
- **Collaboration.** Healthcare leaders, patients, and families work together at an institutional level in such areas as policy and program development, implementation, and evaluation; health care facility design; professional education; and delivery of care.

A model committed to improving medical care from a patient-centered approach is the Planetree model (Frampton, Gilpin, & Charmel, 2003). This model was founded in 1978, and the first hospital based on this model was opened in 1985 and still operates today. The elements of the model include putting the patient first, informing and empowering diverse populations, promoting healing partnerships and environments, and integrating complementary and alternative practices into conventional health care. Nutrition, spirituality, and healing arts are also integral components of care. Strategies are offered on how to incorporate these elements of patient-centered care into physical aspects of physical architecture, environmental design, nutrition, and art, massage, and music therapy.

The Quality and Safety Education for Nurses (QSEN) project (sponsored by the Robert Wood Johnson Foundation) provides what is probably the most accepted definition of patient-centered care. QSEN defines patient-centered care as the nurse’s ability to allow the patient (or designee) full control and full collaboration with the healthcare team to provide coordinated care based on patient preferences (Quality and Safety Education for Nurses [QSEN], n.d.).

QSEN used the competencies outlined by Greiner & Knebel (2003) to define six competencies and proposed targets for nursing education: patient-centered care, team work and collaboration, evidence-based practice, quality improvement, safety, and informatics.

**EMPOWERING NURSES TO PROVIDE PATIENT-CENTERED CARE**

**Holistic Care**

Several parallels can be drawn between patient-centered care and *holistic nursing*. Within patient-centered care, the concept of putting the patient first is similar to the holistic concept of focusing on the patient as a multisystem person. Patient-centered care promotes informing and empowering diverse populations, whereas holistic nursing promotes control on the part of patients and their support systems. The healing partnerships of patient-centered care and the setting of mutual goals in holistic nursing are comparable (Erickson, Tomlin, & Swain, 1983; Frampton et al., 2003). The biopsychosocial perspective and the multidimensionality of human existence are advocated by both holistic nursing and patient centered care (Lauver et al., 2002), and holistic nursing ideals parallel the key components of patient-centered care. Table 9-1 delineates the different aspects of the traditional model of healthcare delivery, the patient-centered
Nursing Roles

Although all nurses learn about holistic nursing in nursing school and are probably aware that healthcare facilities usually support patient-centered care, implementation of patient-centered care into practice requires more than just having knowledge of the definition, models, policies, and procedures (Small & Small, 2011). In order to apply their knowledge, nurses need the support of their managers to motivate them. Balik, Conway, Zipperer, and Watson (2011) identified key drivers that are needed to help nurses apply their knowledge of patient-centered care to practice. The first was to engage their “hearts and minds” with shared values of the staff and leadership (p. 9). The remaining four key drivers were to create respectful partnerships, provide reliable care, and deliver evidence-based care (Balik et al., 2011).

EMPOWERING PATIENTS

Patients may not be accustomed to directing their own health care and it may be confusing to them. Nurses and nurse leaders can help guide patients in directing their own care (Small & Small, 2011). Knowledge is essential for patients to become empowered participants in their own care. Nurses can provide information about the patient’s disease and treatment options; however, to empower patients with this information, the nurse needs to engage the patient. Handing patients sheets of information about their diseases and recommended treatments is rarely successful in empowering patients. Nurse-patient engagement is necessary for patient empowerment to take place. With personal engagement, the nurse can assist the patient in making healthcare decisions that reflect the patient’s own preferences. The Agency for Healthcare Quality and Research (AHRQ) has developed tools to assist patients who are participating in their health care. Some of the recommendations that nurses can discuss with patients include:

- Speak up if you have questions or concerns.
- Keep a list of all your medications.
- Make sure you get the results of all tests and procedures.
- Talk with providers about treatment options.

( Agency for Healthcare Quality and Research, 2002)

One interesting concept is that of a serving leader introduced by Greenleaf in 1971 (Greenleaf, 2008). A serving leader interacts with patients, families, and other employees, with the intent to improve the lives of the people being served. The serving leader exhibits vision, humility, accountability, drive, and leadership and develops self and others (Greenleaf, 2008). With that concept in mind, and appreciating the multiple dimensions of patient-centered care, nurses can empower patients to direct their own health care.

Multiple Dimensions of Patient and Family

Nurses can attest that patients present with a variety of attitudes, knowledge, and expectations that influence their healthcare outcomes. Therefore, it is important to integrate an understanding of multiple dimensions of patient-centered care. To appreciate the healthcare situation through the patient’s eyes, the nurse should respect and encourage the patient and family to express values, preferences, and needs. This information must be included in the plan of care and evaluation of care to make sure that it is communicated to other members of the healthcare team. The nurse should value the patient’s expertise of his or her own health and symptoms because patients present with previous life experiences and different knowledge levels. When a patient is in pain, eliciting expectations from the patient and family for relief from pain, discomfort, or suffering and instituting effective treatments in response to their preferences is especially important (QSEN, n.d.).

<table>
<thead>
<tr>
<th>TABLE 9-1: COMPARISON OF HEALTHCARE MODELS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Model Type</strong></td>
</tr>
<tr>
<td>Focus (person)</td>
</tr>
<tr>
<td>Focus (type)</td>
</tr>
<tr>
<td>Patient Emphasis</td>
</tr>
<tr>
<td>Model Aim</td>
</tr>
<tr>
<td>Care Environment</td>
</tr>
</tbody>
</table>

**FIGURE 9-1: BIOMEDICAL HEALTHCARE MODEL AND PATIENT-CENTERED HEALTHCARE MODEL**

Traditional, Biomedical Healthcare Model | Patient-Centered Healthcare Model
Patient Diversity

Nurses care for patients from diverse cultural, ethnic, and social backgrounds. Being culturally sensitive, by eliciting the patient’s cultural background and being respectful of diversity, helps to create active partnerships and promote health (QSEN, n.d.). See Box 9-1 to review a case study involving a young, male Latino patient and aspects of care related to cultural sensitivity. Answers to the case study questions can be found in Box 9-2. Nurses may not recognize their personally held attitudes about working with patients from different ethnic, cultural, and social backgrounds; therefore, it is imperative that nurses value an individual’s or a group’s unique cultural perspectives and differences that vary from their own.

COMMUNICATION

Personal Communication Skills

Effective communication skills are imperative in providing patient-centered care as well as in creating a culture of patient-centered care. A face-to-face encounter includes verbal and nonverbal expressions that must be acknowledged to communicate therapeutically (Maizes et al., 2009).

Therapeutic communication includes three phases: orientation, escalation, and outcomes (Yoder-Wise, 2011). During the orientation phase, the patient may feel anxious, especially if he or she is not acclimated to the concept of patient-centered care and expects the traditional health care model, in which the physician makes all decisions. During the escalation phase, emotions are increased. De-escalation through open communication can develop trust through respectful communication. During the outcome phase, a relationship between the patient and nurse should develop, with a mutual willingness to communicate honestly.

Communication skills are also required to convey patient information and care to other members of the healthcare team. Patient information should be communicated during every transition of care to assure coordination, integration, and continuity of care.

Common Barriers

Barriers to communication can cause negative patient outcomes. An example is a patient who is too embarrassed to ask for assistance to the bathroom. The nurse can prevent a potential fall by respectfully engaging the patient in a discussion about toileting. Another example that nurses see too often is the patient who is afraid to ask the physician a question. The nurse, as a patient advocate, should intervene, whether in the physician’s office or during hospital rounds, to facilitate discussions between the physician and the patient. The nurse could approach this situation by asking the patient to share information about lack of total pain relief after receiving medication. By giving the physician the complete picture, additional pain interventions can be instituted. Yet another common barrier to communication is the perception by the patient that he or she is not being listened to by the nurse or other provider. The patient must feel that others are paying attention to what he or she is saying for communication to be successful.

A critical examination of common barriers can prevent problems with patient and family communication. The patient and, with the patient’s permission, families (or surrogates) should be actively involved in every aspect of care to improve the effectiveness of patient care and promote health.

Limits and Boundaries

Nurses must recognize that conflicts may occur between patient rights and organizational responsibility for professional, ethical care. For example, the patient has the right to access personal health records; however, the nurse must know the organizational policy to be able to provide guidance to the patient about accessing the records (Centers for Medicare & Medicaid Services, 2010). Even when conflicts occur, nurses need to appreciate shared decision making with empowered patients and families.

Pain and Suffering

As stated previously, the nurse must assess the expectations of the patient and family for relief from pain, discomfort, or suffering. Values and beliefs about pain and pain management can influence outcomes in the management of pain. The nurse should also assess the extent of pain and suffering as well as any emotional discomfort that may be present. Based on the assessment and the patient’s expectations, treatment to relieve pain and suffering should be initiated and communicated to the healthcare team. Some nurses hold generalized beliefs about pain management, which should be recognized and considered; however, current knowledge about evidence-based practice findings and the most effective interventions for the patient’s specific pain must be employed by the nurse.

TECHNOLOGY

Electronic Health Records

Electronic health records (EHRs) contain patient information, such as demographics, medical history, past and present medication use, allergies, immunization status, laboratory test results, radiology images, vital signs, billing information, and other personal information, such as age and weight. This type of health record can communicate and streamline patient care and workflow at a healthcare facility. Depending on the software (and there are many different systems), it can also increase safety and enhance evidence-based practice and outcomes reporting.

Nurses and nurse leaders are on the forefront of EHR documentation and must be proficient in navigating the software systems used at the facilities where they are employed. Patient care is communicated and coordinated through the EHR system, which can assist the nurse in reducing errors and improving patient-centered care.

The disadvantages of EHRs are privacy concerns and legal issues that could arise. Nurses must guard patient confidentiality of protected health information in EHRs.

Medication Errors

Medication errors are alarming and disturbing. The adverse outcomes that may result from such errors include: an extended length of hospital stay, unintended drug events, adverse drug reactions and drug events, significantly increased healthcare costs, and patient deaths. The learner is referred to Box 9-3 to review facts and data about medication errors that occur in healthcare facilities (mainly hospitals). Blaming others when an error or near miss occurs does not solve the problem. Nurse managers must foster an environment of openness so that nurses will report medication errors. Understanding the causes of medication errors, through analysis, and designing system improvements are the best ways to decrease medication errors. Patient-centered care can help reduce medication errors through vigilance and monitoring by patients, families, and other members of the healthcare team.

**Box 9-1: Case Study – Cultural Sensitivity**

Nurse Jones admitted a 5-year-old male patient of Latino descent to a pediatric unit. The patient is bilingual and speaks Spanish and English. His mother speaks only Spanish and is at the bedside. The patient is 1-day post-op following surgery to correct bilateral clubfeet. Nurse Jones assesses the patient’s pain using the Wong FACES pain rating scale. She asks the patient to rate his pain on the 0 to 5 scale. The patient points to level 2, which is a low rating for the pain usually experienced after this surgery. Based on the protocol for pain medication administration, Nurse Jones does not administer an analgesic to the child. Later, when Nurse Jones picks up the breakfast tray, she notices the food is untouched.

**Discussion Questions**

1. Why do you think the patient didn’t eat his breakfast?
2. What information about the patient’s background would have been important to know as it relates to the pain assessment?
3. What should the nurse have done to improve this negative outcome?

See Box 9-2 for answers to these case study questions.

**Box 9-2: Answers to Case Study – Cultural Sensitivity**

1. The patient is in pain and needs pain medication.
2. Hispanic males tend to underrate their pain, even as young as 2 to 3 year olds.
3. Nurse Jones would have been better prepared to appropriately administer pain medication if she was more knowledgeable about the patient’s cultural background. Any nurse caring for a person from a different culture should take upon him or herself to learn about cultural norms relative to pain management.
Evidence-Based Care

With the advent of personal computers in the 1980s and the explosion of information technology, evidence-based care has evolved substantially over the last several decades. Evidence-based care is a movement rooted in the medical trend of evidence-based medicine, which has influenced other professions, including nursing (Varnell, Haas, Duke, & Hudson, 2008). Evidence-based care within nursing has become essential for nursing knowledge and is currently a practice expectation (Edwards, Chapman, & Davis, 2002). The remarkable increase in initiatives, such as the promotion of evidence-based systems (Quality of Health Care in America Committee of the IOM, 2001; Greiner & Knebel, 2003), has left many nurses struggling to make sense out of the overwhelming amount of information available for evidence-based care (Varnell et al., 2008). The premises of evidence-based care include: research-based clinical interventions, increased focus on individualized care, acknowledgment of personal clinical expertise, and coordination of the informed consumer’s expectations with the provider’s care, based on the best evidence available (Varnell et al., 2008). Melnyk & Fineout-Overholt (2011) define evidence-based care as a problem-solving approach that supports the use of the most current scientific evidence, clinicians’ expertise, and patient’s preferences and values. Sigma Theta Tau International’s definition of evidence-based care includes the integration of best evidence available, nursing expertise, and the values and preferences of individuals, families, and communities.

The utilization of evidence-based care has improved patient care outcomes and healthcare provider retention (Melnyk & Fineout-Overholt, 2011). Varnell and colleagues (2008) point out that traditional evidence-based care places systematic reviews and meta-analyses of randomized controlled trial studies as the “gold standard” of evidence. However, Tappen (2011) argues that empirical knowledge alone is insufficient in meeting holistic care needs. Despite the various perspectives of evidence-based care, the potential to advance nursing knowledge and improve patient care still exists. Nurses should recognize the hierarchy of the evidence, and include them as part of their literature critique, when used for decision making. Nurse leaders should promote the use of evidence-based practice models to implement best care practices. (See Box 9-4 to determine how to devise a research question.) Evidence-based care includes evidence not included in scientific research that can be relied on for practice decisions, such as clinical experience, guidelines, patient preferences, and valid research findings (Varnell et al., 2008). Charlton, Dearing, Berry, & Johnson (2008) state that the paradigm shift to patient-centered care places responsibility with the professional caregiver to be well-informed and to deliver competent care.

PREPARING NURSES FOR DECISION MAKING

Clinical Simulation

Clinical simulation is an endeavor to reproduce aspects of a clinical situation, with the purpose of preparing a nurse for a real event in clinical practice in terms of psychomotor skills, decision making, and critical analysis. Clinical simulation has been part of nursing education and updating skills for generations; however, within the past decade, technology has allowed a more sophisticated experience. Clinical simulation is currently described along a continuum from low-fidelity to high-fidelity (Jefferys, 2007). Low-fidelity simulation includes the use of case studies, computer-assisted instruction, computerized educational games, and role-play. Low-fidelity clinical simulation strategies are a non-threatening tool that allows the nurse to independently learn a new skill in a lab environment. These simulation experiences need to be available to nurses during open lab times, and education departments need to post a schedule with days and hours of operation.

All health professionals can learn by participation in low-definition simulation experiences. An investigation with internal medicine residents supported that their confidence increased after learning information about cardiac resuscitation and performing cardiopulmonary resuscitation on low-definition mannequins (Healey et al., 2010). As a result of the simulation experience, information in the curriculum on resuscitation was revised to add these clinical laboratory experiences.

Medium-fidelity simulation helps learners to practice specific psychomotor skills by making use of task trainers, low-technological mannequins, intravenous insertion computerized trainers, and 2-D computer-based simulations (virtual worlds). Hands-on practice for invasive procedures, such as nasogastric tube insertion, Foley catheter insertion, and tracheostomy suctioning, on medium-definition simulation mannequins may decrease the nurse’s anxiety because she is not causing discomfort to a patient. The clinical simulation lab is a safe learning environment for the nurse.

Cunningham (2010) reported that use of medium-definition mannequins was beneficial in LPN programs. Their use offered an alternative to the more expensive high-fidelity mannequins that require more than one person to operate. Likewise, in practice settings, nurses do not always need high-fidelity simulation mannequins to learn certain procedures such as Foley catheter insertion and care.

High-fidelity simulation offers a high level of realism and offers the learner the opportunity to interact with a computerized mannequin in a simulated environment while being filmed and recorded. High-fidelity simulation mannequins have audio features in which the mannequin cries, yells, and mimics other sounds such as vomiting. The mannequin can be programmed to have a myocardial infarction, and the heart rate and rhythm can be seen on an electrocardiogram. The nurse must intervene by knowing the exact cardiac rhythm, how to interpret vital signs, and know what medications to give and how to administer them. This means that the nurse must not only know the appropriate medications, but also their dosage parameters (including specific cardiac drug IV drip rates).

BOX 9-3: FACTS ABOUT MEDICATION ERRORS

- Estimates suggest that more people die in a given year as a result of medical errors (including medication errors) than from motor vehicle accidents (43,458), breast cancer (42,297), or AIDS (16,516).
- Medication errors alone, occurring either in or out of the hospital, are estimated to account for 7,000 deaths annually.
- Adverse drug events (ADEs) cause more than 770,000 injuries and deaths each year and cost up to $3.6 million per hospital.
- Patients who experienced unintended drug events remained in the hospital an average of 8 to 12 days longer than patients who did not experience such events. These added days mean that their hospital stays cost $16,000 to $24,000 more.
- One recent study conducted at two prestigious teaching hospitals found that about 2 out of every 100 admissions experienced a preventable adverse drug reaction event, resulting in an average increased hospital costs of $4,700 per admission, or $2.8 million annually for a 700-bed teaching hospital.
- Two large studies, one conducted in Colorado and Utah and the other in New York, found that adverse events occurred in 2.9 and 3.7 percent of hospitalizations, respectively.
- Preventable ADEs cost the healthcare system in the United States $2 billion annually.
- Infusion devices account for up to 35% of all medication errors that result in significant harm (Class 4 and 5). The most common errors are manually programming incorrect infusion parameters, failure to ensure the right patient receives the right medication, and tampering with infusion parameters by unauthorized users.

(Bates et al., 1997; B. Braun Medical, 2013; Brennan et al., 1991; Heron, 2012; Morimoto, Gandhi, Seger, Hsieh, & Bates, 2004; Phillips, Christenfeld, & Glynn, 1998; Kohn, Corrigan, & Donaldson, 2000)

BOX 9-4: MODEL FOR EVIDENCE-BASED PRACTICE

1. Formulate a clinical question.
   a. A method to formulate a clinical question is referred to as a PICO question: population, intervention, comparison, and outcome (PICO). An example of a PICO question follows:
   - For patients at risk for in-hospital falls (P), does the introduction of hip protectors (I) reduce the incidence of hip fractures (O) compared with floor mats (C)?
2. Seek the best evidence to answer the question.
3. Critically appraise the evidence.
4. Integrate or apply the evidence with clinical expertise.
5. Evaluate the effectiveness of an evidence-based practice change.

(Melnyk & Fineout-Overholt, 2011)
After the high-definition simulation event, the nurse can review his or her performance and learn what was done correctly and where improvements are needed. In this instance, the staff development nurse can assist the nurse through a debriefing process about best practice procedures in a cardiac emergency.

Hospitals frequently require nurses who are transferring to different units, especially critical care settings, to orient to the new units using clinical simulation. This is beneficial to the nurse who is transferring to a different specialty unit such as obstetrics, where high-definition mannequins mimic the birth process, or orthopedics, where mobility devices such as continuous passive motion machines are used to increase knee flexion after a total knee arthroplasty. The learner is referred to Box 9-5 to view the different levels of clinical simulation.

Simulated learning experiences are used in other fields, such as the military and aviation, where making sound decisions in a time-sensitive situation is imperative (Carron, Trueb, & Yersin, 2011). Like nurses, military personnel have to critically think and respond in emergent situations. The military uses a high-fidelity simulation called Crew Resource Management (CRM) to manage flight situations. Important components of CRM include:

- Situational awareness
- Self-awareness
- Planning
- Decision making
- Communication
- Leadership
- Emotional climate
- Stress management
- Assertiveness training.

Nurses must be knowledgeable and able to operationalize these same components. Simulation programs produce interactive scenarios in realistic environments, using lifelike patients in clinical situations. Practicing teamwork and communication skills enhances clinical reasoning and experiential learning.

Nurses also are required to critically analyze patient situations and make decisions quickly. With high-fidelity simulation, nurse learners can practice these skills in a safe environment. This model of learning also offers the opportunity to experience a wide-range of uncommon clinical situations as well as situations that would be too risky for a novice to experience with a real patient (Jeffries, 2007). Nurse leaders should require staff to use clinical simulation to update skills and orient new nurses to their environments.

**Experiential Learning**

Experiential learning is preferred over traditional lecture-type instruction that includes an expert (teacher) relating facts and the teacher’s interpretations of those facts to the learners. Learning needs to be experienced and experiences must be worthwhile, generate interest, and include problems that prompt curiosity and a desire for more information (Archambault, 1975). Ultimately, abstract knowledge should be applicable to learners’ personal lives. Learners are able to integrate information into their lives only when they are provided the opportunity to reflect on their experiences.

A nurse leader may have an opportunity to mentor an orientee or new nurse. In this role, the nurse leader is charged with facilitating experiential learning experiences for the new employee. This may include self-evaluation, preceptor evaluation, and setting goals with the new employee to offer occasions to learn, apply, and reflect. The nurse leader and preceptor serve as role models and offer guided autonomous opportunities to prepare nurse learners to make sound clinical decisions.

**SAFETY**

Information and technology skills are essential for safe patient care practice in today’s healthcare environment. Nurses and nurse leaders must seek new knowledge and education about how information is managed in care settings and become proficient in navigating the information system before providing patient care. Lack of information management knowledge can result in a miscommunication or an error. For example, a nurse could double a dose of medication if not familiar with the functionality of the medication administration system or document in the wrong area of the EHR. Health professionals must embrace and appreciate the need to seek lifelong continuous learning of new information technology skills.

**SUMMARY**

Patient-centered care has various definitions. One of the most comprehensive definitions is offered by the IPFCC (n.d.). The IPFCC identified four core concepts: respect and dignity, information sharing, participation, and collaboration, which encompass patient- and family-centered care. Nurses learn components of patient-centered care in nursing school. Sometimes, nurses who work in conventional medical environments find it difficult to practice patient-centered care. For this reason, nurse leaders must empower nurses through motivation and engagement.

Patient empowerment and shared decision making are basic components of patient-centered care. Nurses can promote these concepts through improved communication skills. Electronic health records are a tool to improve communication between healthcare professionals, and the computer software systems in many healthcare facilities offer resources for evidence-based care. In today’s high-tech environment, information and technology skills are essential for safe patient-centered care.

**Answer the self-assessment questions for Chapter 9 at the end of the course.**

---

**Box 9-5: Continuum of Clinical Simulation**

<table>
<thead>
<tr>
<th>Level of Clinical Simulation</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Fidelity</td>
<td>Case studies, Computer assisted instruction, Computerized educational programs, Resuscitation, Role-play</td>
</tr>
<tr>
<td>Medium Fidelity</td>
<td>Task trainers, Low-tech mannequins, Intravenous insertion trainers, 2-D computer-based simulations (virtual worlds)</td>
</tr>
<tr>
<td>High Fidelity</td>
<td>Computerized mannequin in a simulated environment while being filmed and recorded</td>
</tr>
</tbody>
</table>

---

**CHAPTER 10: MANAGING CONFLICT AND STRESS**

**CHAPTER OBJECTIVE**

After completing this chapter, the learner will be able to describe strategies for managing conflict and stress.

**LEARNING OBJECTIVES**

After reading this chapter, the learner will be able to:

1. Define conflict and stress.
2. Describe win and lose strategies for managing conflict in healthcare organizations.
3. Describe the five modes of conflict resolution.
4. Identify resources available to help individuals manage work-related stress.
5. Differentiate self-management from time management.

**OVERVIEW**

Stress is a natural component of everyday life. Nurses must learn to cope with stressors that occur at work and at home. Conflict within the workplace can never be eliminated; however, it can be managed. Conflict comes about when people feel strongly about an issue (Finkelman, 2012). Boggs (2011) defines conflict as the “tension arising from incompatible needs, in which the actions of one frustrate the ability of the other to achieve the goal” (p. 272).

In this chapter, stress and conflict management along with time management strategies will be explored as they relate to a nurse’s ability to be resilient and cope with work and life stressors. Working with minimal stress enhances workplace productivity and efficiency in nursing practice. Outstanding nurse managers actively develop skills...
to confront stressors directly. They find creative ways to handle workplace tension and they manage workplace conflict effectively and in a timely way. Conflict can be positive if it propel people forward to work through concerns and problems. Identifying the cause of conflict and working through the modes of conflict resolution can help nurses find healthy ways of coping with stressful workplace situations.

**CONFLICT**

Conflict exists in all work environments. It usually precedes change; therefore, it has positive aspects. However, many nurses associate conflict with negative scenarios and outcomes. The profession of nursing is primarily female-dominated, with a public that views nurses as nice, self-sacrificing women (Kelly, 2006). The public may view active engagement in conflict negatively, even though resolution can lead to better outcomes. Conflict resolution, positive as well as negative, frequently is seen in labor disputes and union negotiations.

Conflict can be healthy! Nurses need to change their attitudes toward conflict and view conflict as a natural, unavoidable prerequisite to positive changes in healthcare organizations (Sullivan & Decker, 2005). Conflict occurs when individuals or groups have disagreements about goals, ideas, values, beliefs, attitudes, feelings, perceptions, opinions, and actions regarding issues of importance (Finkelman, Jamerson, Marshall-Chura, Monahan, & Parsons, 2005; Kelly, 2006; Sullivan & Decker, 2005; Yoder-Wise, 2011). Conflict that is managed positively (as controversy) versus negatively (as seen in disagreements) can yield good outcomes, deepen relationships, and promote work-group cohesion (Finkelman et al., 2005).

**Types of Conflict**

Conflict occurs in all aspects of life, including personal and work lives (Finkelman et al., 2005; Yoder-Wise, 2011). A frequent cause of workplace conflict is assignment decisions; however, workplace conflict also can occur because of other reasons. Conflict can be classified into three groups: intrapersonal conflict, interpersonal conflict, and intragroup (organizational) conflict.

**Intrapersonal Conflict**

Intrapersonal conflict occurs within an individual. For example, a nurse is deciding whether to increase her work hours to help with family finances or to not increase them to be at home more with her children. Another common occurrence is when a nurse desires a position that requires further education, but he or she cannot afford the time or the money needed to accomplish it. In practice, a nurse can be conflicted when he or she wants to spend more time with a dying patient, but has other tasks to complete and patients who need attention. Another intrapersonal conflict commonly experienced by nurses is being asked to work beyond their scheduled shifts when they want to leave to attend to other issues in their lives. This conflict arises because the nurses can see that patients need care and there are not enough nurses on duty. A manager may experience this level of conflict when needing to address a sick time abuse issue with a nurse who attends the same church that he or she attends.

**Interpersonal Conflict**

Interpersonal conflict occurs when two or more people do not agree on issues or the best way to manage a particular problem. For example, nurses may have differing opinions on how to staff their unit during the holidays. Interpersonal conflicts also occur between healthcare providers and patients (for example, a patient may resist recommended changes in his or her treatment protocol).

**Intragroup Conflict**

Intragroup (or organizational) conflict can occur if a nurse perceives hospital policies and protocols to be unfair. The organizational structure may cause conflict if the staff do not feel that the management listens to their concerns about quality of care issues or work arrangements. If staff perceive that management places more importance on the hospital’s image and its fiscal bottom line than on providing care for the indigent, organizational conflict may ensue. Interestingly, nurses working in hospitals with Magnet recognition and who practice in shared governance models display more decision-making autonomy, but can also experience positive and negative conflict (American Nurses Credentialing Center, 2005). As staff nurses become more engaged in and accountable for quality of care outcomes, they demand a greater voice in management; hence, a look at role redefinition is suggested.

Conflict is an everyday occurrence and, if approached with the correct attitude, it can produce many positive outcomes. Nurses may utilize different modes of conflict resolution.

**Managing Conflict**

The three basic strategies for managing conflict are: win-lose, lose-lose, and win-win (Sullivan & Decker, 2005).

- **Win-Lose**
  - Scenarios commonly occur in groups.
  - Voting on issues, and the concept of “majority rules,” places some people on the winning side and others on the losing side of a situation. Losing can erode group cohesion and diminish the authority of the leader.
  - Lose-lose scenarios involve neither party winning or, on the other hand, both parties losing. In the case of both parties losing, the resolution reached is not satisfactory to either party. For example, an arbitrator in union contract negotiations takes away something from each party, and neither party gets exactly what it wanted. This is a classic example of a lose-lose strategy in conflict resolution.
  - Win-win scenarios involve parties working together to meet the goals and objectives of everyone involved. In this conflict management strategy, group consensus is reached through full investigation of a problem, needs of the group are understood, and a solution is agreed upon. No voting, averaging, or other traditional dispute measures are used. True group consensus occurs.

**Conflict Resolution Modes**

Five different approaches can be used to manage conflict: avoiding, accommodating, competing, negotiating, and collaborating (Finkelman et al., 2005; Sullivan & Decker, 2005; Yoder-Wise, 2011).

- **Avoiding** (or withdrawing) involves not dealing with conflict. Parties are aware of the conflict, but do not acknowledge it or attempt to resolve the issues.
- **Accommodating** (or smoothing) involves placing the group’s needs over the individual’s needs. Nurses choose this strategy when they want to maintain a peaceful work environment.
- **Competing** has one goal – to win at all costs. People pursue their own agendas over the needs of, or costs to, others involved in the conflict. The losing parties are left angry and frustrated. Managers commonly use this strategy when a quick decision must be made.
- **Negotiating** (or compromising) involves give and take from the parties involved in the conflict. In this conflict resolution approach, rewards are divided among the parties and result in the parties securing their most important priorities whenever possible. This conflict resolution strategy commonly is used in contract negotiations because it invites a middle ground, where everyone participates and each side is placated to a certain degree.
- **Collaborating** is the most creative form of conflict resolution. This approach is the opposite of competing and avoiding, in which parties work together to find the best possible solution. A commitment among group members and higher levels of problem analysis are seen in this mode.

See Table 10-1 to review strategies for conflict management. Also see Box 10-1, which presents a case study related to conflict resolution.

**STRESS**

Stress, like conflict, is a natural occurrence in life. Nurses must learn positive ways to cope with stress and stressors in the work environment. Stress is defined as a nonspecific response to threatening demands from the environment (Sullivan & Decker, 2005). Stress can manifest itself in physical, psychosocial, or spiritual ways, which are sometimes referred to as stressors. Selye (1976) explained that people adapt to stress as a way of coping. When people are confronted with negative stressors, the physiological reaction referred to as the “fight or flight” response helps them survive.

<table>
<thead>
<tr>
<th>TABLE 10-1: STRATEGIES FOR MANAGING CONFLICT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conflict-Management Strategy</td>
</tr>
<tr>
<td>---------------------------------</td>
</tr>
<tr>
<td>Win-Win</td>
</tr>
<tr>
<td>Win-Lose</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Lose-Lose</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
BOX 10-1: CASE STUDY – CONFLICT RESOLUTION

Betty has worked on an oncology unit for 2 years. She was complimented by the nurse manager on her work and was given the additional duties of being a part-time charge nurse. Occasionally, when the oncology unit has a low census, Betty is asked to work on the general medical and surgical units. Betty dislikes leaving her own unit but cooperates because she feels she can handle the clinical assignments and she wants to demonstrate her flexibility.

One Saturday evening when she arrives at work, Betty is asked by the nursing supervisor to report to obstetrics (OB) because the oncology unit has a low census and it is Betty’s turn to be pulled to another unit. Betty explains that she knows nothing about OB and she cannot take the assignment. The supervisor insists that she is the most qualified person to accept the assignment and says, “Just go and do the best you can.” The nurse manager is not on duty, and the full-time oncology charge nurse says she is not comfortable advising Betty in this conflict. Betty is torn by personal, professional, and organizational conflict.

Discussion Questions
1. What should Betty do?
2. What resources can help guide this decision?
3. What conflict resolution strategy could be appropriately employed?
See Box 10-2 for answers to these questions.

BOX 10-2: ANSWERS TO CASE STUDY – CONFLICT RESOLUTION

1. Betty is a loyal employee and has cooperated with being pulled to other units in the past. She should try to adopt a conflict resolution strategy that she can live with and that meets the needs of her patients.
2. Several documents and people should be able to help Betty resolve this conflict. For example:
   a. Betty should refer to the facility’s policy book. Specialty units commonly require discipline-specific orientations. Betty has never been formally oriented to the OB unit.
   b. Betty should refer to the Joint Commission manual. Unit-specific orientations are addressed.
   c. Because the charge nurse was not helpful, Betty can consult with a seasoned nurse whom she trusts, if one is on duty.
3. Betty has several conflict resolution options from which to choose; however, in this scenario, negotiating is a good mode for conflict resolution. Betty should share that she is willing to accept the assignment if she is:
   – assigned to the postpartum unit and not the nursery or labor and delivery areas because her professional nursing experience is limited to the care of adults and she has not been oriented to either of these specialty areas
   – assured that one of the regular OB nurses is in charge of the postpartum unit
   – paired with another experienced OB nurse for questions that arise.

TABLE 10-2: PHYSICAL, MENTAL, AND WORK-RELATED SYMPTOMS OF STRESS

<table>
<thead>
<tr>
<th>Type</th>
<th>Symptom</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical</td>
<td>• Fatigue</td>
</tr>
<tr>
<td></td>
<td>• Headache</td>
</tr>
<tr>
<td></td>
<td>• Insomnia</td>
</tr>
<tr>
<td></td>
<td>• Hypertension</td>
</tr>
<tr>
<td></td>
<td>• Digestive disturbances</td>
</tr>
<tr>
<td>Mental</td>
<td>• Anxiety</td>
</tr>
<tr>
<td></td>
<td>• Frustration</td>
</tr>
<tr>
<td></td>
<td>• Guilt</td>
</tr>
<tr>
<td></td>
<td>• Depression</td>
</tr>
<tr>
<td></td>
<td>• Inability to concentrate</td>
</tr>
<tr>
<td></td>
<td>• Forgetfulness</td>
</tr>
<tr>
<td></td>
<td>• Burnout</td>
</tr>
<tr>
<td>Work-Related</td>
<td>• Strained coworker relations</td>
</tr>
<tr>
<td></td>
<td>• Depersonalization</td>
</tr>
</tbody>
</table>

Stress also can be positive. Positive stress propels a person forward, such as the stress a nurse experiences when he or she is attending college while simultaneously maintaining employment. Although the nurse is extremely busy, he or she is able to manage a job and be successful in school. This positive stress situation is referred to as eustress.

Common stressors that nurses experience in practice are: working short of staff or with too many unlicensed assistive personnel relative to patient acuity, patients who have uncontrolled pain or who are dying, and demanding families. In today’s healthcare environment, nurses are experiencing downsizing and restructuring, despite the fact that patient quantity and illness acuity is static or rising. This stressor can cause nurses to feel unsafe because medication and procedural errors can occur, and nurses may feel forced to deliver care below the minimum acceptable standard. Nurses also may have personal stressors, such as family obligations for child care or elderly parents living in the home without adequate assistance.

When stress exceeds a nurse's ability to cope, a state of disequilibrium can occur (Sullivan & Decker, 2005), which may result in physical, mental, and work performance problems. (See Table 10-2 for a list of problems that can occur due to unresolved stress.) Sometimes, nurses cannot manage stress by themselves (Yoder-Wise, 2011). In highly-charged situations, nurses may try using coping mechanisms to manage their stress. Coping is how people respond to threatening situations. When nurses are faced with demands that are taxing and exceed their internal resources, they may try to manage by constantly changing coping mechanisms. When coping mechanisms are exhausted, burnout occurs.

Burnout

Burnout is defined as chronic unresolved stress. Burnout manifests as emotional, physical, and mental fatigue that may be accompanied by feelings of helplessness and hopelessness. Burnout adversely affects motivation and work productivity and leads to depersonalization (the inability to engage in relationships and meaningful interactions with patients and coworkers). See Box 10-3 for a stress-related case study.

Resources for Coping with Work-Related Stress

The best way to deal with stress is to prevent prolonged stress from occurring. Nurses have several support systems available to help with stress-related issues (Yoder-Wise, 2011).

Social Support

Social support, including friends, nursing peers, and other coworkers, can help a nurse through the initial onset of stress. In many cases, the ability of these cohorts to relate to what the nurse is experiencing is viewed as helpful. Friends and coworkers can offer their perspectives on effective ways they have managed their own stress. Peer support helps the nurse work through feelings in a nonthreatening way and can help the nurse verbalize his or her feelings.

BOX 10-3: CASE STUDY – WORK-RELATED STRESS

Julie is a registered nurse who has practiced on a surgical unit for the past 17 years and weathered many changes during that time. The hospital is currently experiencing some quality management issues and is going through a period of change, in which they are consolidating some units and introducing more UAP. Julie works full time and is frequently in charge on the 3 to 11:30 p.m. shift. Lately, she reports feeling fatigued and depersonalized, and her level of productivity has declined. She believes that care quality has declined and wants the changes that are occurring to stop so she can resume providing good patient care. Other staff nurses note that Julie does only the minimum required by her job and that she leaves promptly at 11:30 p.m.

Discussion Questions
1. What stress-related phenomenon is Julie experiencing?
2. What causes her to feel helpless or hopeless? Why is she decompensating?
3. What can Julie do to function more effectively while at work?
See Box 10-4 for answers to these questions.
Part of managing stress is trying to prevent it by staying focused and organized. Adopting good self-management and time-management strategies can augment the time a nurse has available to achieve personal and professional goals.

Self-Management
Self-management involves striking a balance between one’s work life and one’s family and personal life by setting goals and objectives (Yoder-Wise, 2011). Nurses must also organize their time and activities to reach their target ambitions. To achieve these personal aims, nurses must take control of their lives and organize their careers, personal lives, social activities, and personal selves. Managing personal stress is important. See Table 10-3 to learn more about stress management techniques.

Time Management
Successful time management can reduce many stressors for nurses (Yoder-Wise, 2011). Good time-management skills enhance work productivity. A common adage in health care today is, “doing more with less.” Clearly, this situation creates more demands on a busy nurse’s time. Time management involves appropriate use of tools, technology, and principles to ensure that time is spent on achieving high-priority goals. Nurses need to learn time-management techniques to be as effective as possible in the workplace. See Table 10-4 to learn more about time-management techniques. Electronic calendars, technology tools for communication, and a daily planner can go a long way toward efficiently managing time. Organizing contents on top of a desk and prioritizing what needs to be addressed first in an in-box are also excellent time-management strategies that can help nurses stay organized and focused. See Table 10-5 for techniques for working effectively.

**Summary**
Stress and conflict are natural parts of life that impact a person’s personal and professional well-being. Nurses must adopt healthy ways to cope with stress and learn effective conflict management strategies for specific situations. Preventing stress and conflict is the best intervention; however, this solution is not always possible. Effective self-management and time-management strategies are important components of goal attainment. Knowing external and internal resources can help a nurse stay organized and healthy and maintain productivity at work and at home. Answer the self-assessment questions for Chapter 10 at the end of the course.

**Resources**
American Holistic Nurses Association  
http://www.ahnna.org
American Institute of Stress  
http://www.stress.org
Conflict Resolution Information Source  
http://www.crininfo.org

---

**BOX 10-4: ANSWERS TO CASE STUDY – WORK-RELATED STRESS**

1. Julie is experiencing burnout.
2. Julie’s reaction is related to her inability to cope with the changes at the hospital.
3. Several interventions could be helpful to Julie. She could:
   a. Talk with her peers on the surgical unit because they are most familiar with how the changes in the hospital are impacting patient care on the unit. Peer support is very useful because it may help Julie realize that her peers have experienced the same workplace stressors. Learning how others cope can be helpful to self-coping.
   b. Check to see if the facility has an Employee Assistance Program (EAP). Such programs can be very helpful and may be free of charge.
   c. Seek professional help through a personal physician who can refer Julie to a clinical psychologist, psychiatrist, or mental health counselor.

**TABLE 10-3: STRESS MANAGEMENT TECHNIQUES**

<table>
<thead>
<tr>
<th>Technique</th>
<th>Actions</th>
</tr>
</thead>
</table>
| Physical  | Prioritize your health  
Exercise  
• Do something you like on a regular basis, at least 5 times a week.  
Eat right  
• Eat at regular times.  
• Decrease caffeine and sugar intake.  
• Increase vegetables and fruits.  
Rest  
• Sleep at least 8 hours every night.  
Relax  
• Schedule time to relax.  
• Practice meditation, massage, yoga, guided imagery, prayer, and biofeedback. |
| Psychosocial | Practice self-talk.  
Learn and practice saying “No.”  
Learn communication, time management, and conflict resolution techniques.  
Plan time for family, hobbies, and/or activities.  
Learn about your work environment and how to systematically negotiate effectively.  
Seek professional support.  
Begin networking, join a support group, find a mentor, and mentor others. |

**TABLE 10-4: TIME MANAGEMENT TECHNIQUES**

<table>
<thead>
<tr>
<th>Technique</th>
<th>Actions</th>
</tr>
</thead>
</table>
| Get organized | Organize and systematize things, tasks, and people.  
Use basic time-management skills. |
| Focus on goals | Prioritize goals and set up time-lines and action plans.  
Assemble a prioritized “to do” list daily, based on goals. |
| Use tools | Use electronic calendars and planners that are organized to meet your needs.  
Use project management tools. |
| Make time-management plan | Develop an appropriate personal time-management plan.  
Review and revise the plan as needed. |

Counseling
When stress is prolonged, it may be helpful for the nurse to seek professional counseling. Symptoms of prolonged stress include anxiety, uncontrolled crying, and a lack of desire to go to work. Experiencing unresolved stress can cause a nurse to believe his or her well-being is in jeopardy. In this case, the nurse must seek the help of a physician, psychiatric-mental health nurse practitioner, clinical psychologist, or other mental health professional (Yoder-Wise, 2011).

Employee Assistance Programs
Some organizations offer employee assistance programs (EAPs) free of charge. This type of program is beneficial because the professionals who work in them are aware of in-house stressors that nurses encounter. Conversely, nurses may feel awkward having a fellow hospital employee know their mental health issues. In such cases, the provider is bound by professional standards of confidentiality. Furthermore, these individuals are educated to manage difficult scenarios, and often provide counseling services away from the mainstream of employees; thus, they are unlikely to come into daily contact with nurses who need to use EAP services, except through that specific contact.
TABLE 10-5: TIPS TO WORK MORE EFFICIENTLY

<table>
<thead>
<tr>
<th>Technique</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan your day</td>
<td>• Set goals and prioritize.</td>
</tr>
<tr>
<td></td>
<td>• Prioritize a daily “to do” list.</td>
</tr>
<tr>
<td></td>
<td>• Delegate tasks to coworkers and assistants if possible.</td>
</tr>
<tr>
<td></td>
<td>• Keep manager informed of your goals.</td>
</tr>
<tr>
<td></td>
<td>• Maintain your daily plan.</td>
</tr>
<tr>
<td>Plan Activities</td>
<td>• Break projects into small, manageable pieces.</td>
</tr>
<tr>
<td></td>
<td>• Finish one task before you go on to the next.</td>
</tr>
<tr>
<td></td>
<td>• Communicate effectively and plan carefully to make sure a job is done properly the first time around.</td>
</tr>
<tr>
<td></td>
<td>• Schedule time when you will be available for staff members; let colleagues know so constant interruptions can be avoided. Close the door if necessary.</td>
</tr>
<tr>
<td>Develop work habits</td>
<td>• Keep your work area organized and clean.</td>
</tr>
<tr>
<td></td>
<td>• Know your time-wasting habits.</td>
</tr>
<tr>
<td></td>
<td>• Learn to say “no.”</td>
</tr>
<tr>
<td></td>
<td>• When at work, don’t get sidetracked with personal or social tasks.</td>
</tr>
</tbody>
</table>

CHAPTER 11: POWER AND INFLUENCE

CHAPTER OBJECTIVE

After completing this chapter, the learner will be able to describe the impact of power and influence on nursing practice.

LEARNING OBJECTIVES

After reading this chapter, the learner will be able to:
1. Define power.
2. Describe the different types of power.
3. Identify personnel who practice in empowered environments.
4. Describe strategies for developing a powerful image.

OVERVIEW

The discipline of nursing changed during the 20th century, as women began to take a more active role in shaping health policy and leading healthcare organizations. The study of power is interesting because the nursing profession has historically been, and continues to be, predominantly composed of women. Therefore, understanding power, knowing how power can propel the nursing profession forward, interacting with powerful people, and becoming more influential as a profession and as individuals, is crucial to nursing’s future.

This chapter will help nurses understand power and the importance of power in the nursing profession. Influencing and negotiating are important power concepts that must also be understood by nurses.

POWER

Power is viewed by some in a negative light. However, with a national shortage of nurses and an aging workforce, nurses must become comfortable with exerting power to influence healthcare delivery (Courchane, 2011). Power has different meanings to different people. Power is defined as the ability to influence others—in this case, a nurse’s ability to influence others in making healthcare decisions and influencing goals (Huber, 2010; Jones & Malone, 2004; Sullivan & Decker, 2005).

The term empowered environment is commonly used in leadership and management circles. Empowered environments allow nurses to be actively involved in decision making and initiate actions that promote positive patient care outcomes (Marriner-Tomey, 2009; Mason, Leavitt, & Chaffee, 2007). Advanced practice nurses (APRNs), clinical educators, nurse researchers, nurse executives, nurse managers, academicians, and staff nurse leaders are leaders in clinical practice and major players in empowered healthcare settings. Marriner-Tomey (2009) describes empowerment as a means of gaining control to exercise individual power.

Gaining knowledge for empowerment and empowered workplaces is extremely important to the nursing profession (Yoder-Wise, 2011). Nurses must support each other when empowering their practice settings. When power is shared, an individual or, in this case, a group’s power base becomes stronger. Because nurses comprise the largest number of healthcare providers, their collective voice can positively impact patient outcomes.

Types of Power

The eight major types of power are: charismatic, coercive, connection, expert, legitimate, persuasive, referent, and reward. Nurses must understand these types of power in order to interact with the major players in an organization and to understand how power works. Gaining personal knowledge of power enhances a nurse’s ability to work strategically within a healthcare system.

Charismatic power refers to personal power. A person with charismatic power has a natural ability to inspire followership. People with charismatic power are commonly said to have “magnetic personalities.”

Coercive power refers to fear and punishment. For example, a manager may threaten to use disciplinary action if an individual or a group does not comply with his or her requests (Sullivan & Decker, 2005). Individuals react with fear because of the negative outcomes that may occur if they do not comply with the manager’s request or directive.

Connection power refers to formal and informal links to influential and prominent people within social and professional circles.

Expert power refers to an individual’s knowledge, expertise in the profession, and skills. Expert power is associated with the phrase, “knowledge is power.”

Legitimate power refers to an individual’s position within the organization. The higher the person is in the organizational hierarchy, the higher his or her legitimate authority. This type of power is also known as position power.

Persuasive power refers to a person’s ability to provide an effective argument or point-of-view (Dessler, 2001).

Referent power refers to an individual’s association with highly admired and respected people. People with referent power have the ability to attract others.

Reward power refers to a manager’s ability to grant favors. This power base is enhanced through enticements by the manager in exchange for contributions that increase the manager’s goals. Employees comply because of the positive benefits they will receive.

Table 11-1 lists different types of power, examples of people in power positions, and examples of how power is used. By learning more about the positive aspects of power and identifying different power leaders, nurses can enhance their practice and the image of the nursing profession.

Creating a Powerful Image

Self-confidence enhances a person’s image relative to power. Nurses must be cognizant of their images in the work environment, nursing organizations, and within public policy forums (Yoder-Wise, 2011).

Nurses can enhance their images by adopting some commonsense principles (Yoder-Wise, 2011). Table 11-2 describes characteristics that can help nurses to create power images.

Historically, nurses have not been socialized to create power images. However, the nursing profession in the 21st century has an entirely different outlook. Nurses are lobbyists, using their knowledge to influence political and world leaders and hold elected government offices. Advanced practice nurses serve as strong patient advocates. Nurse educators influence and model professional behavior for students and practicing nurses in graduate education programs. Nurse researchers contribute to nursing science and put science-based evidence into nursing practice by revising patient care protocols based on research findings. Evidence-based practice acknowledges nurse researchers for their scholarly accomplishments and positive impact on people’s lives. These roles collectively contribute to the powerful image of professional nursing. Creating a powerful image is important for nurses and the society in which they provide care. (See Box 11-1 for a critical thinking exercise about creating a power image.)

Empowerment

Empowerment is a concept associated with the power inherent in being a member of a group or organization (Huber, 2010). Empowerment gives individual nurses the authority, accountability, and responsibility to make decisions and act upon them freely in the workplace. Leaders instill in nurses their belief in them and reinforce the nurses’ confidence in their own capabilities (Porter-O’Grady & Malloch, 2013). They encourage openness, active engagement in issues, creativity, willingness to change, honesty, collaboration, ethical standards,
organizational strategies are viewed by others as being powerful. The ability to balance power and respect in decisions is important, as hospital environments are seen in hospitals that have achieved Magnet status.

Nurses are given the authority and responsibility for making decisions that positively impact patient care. Resources are dedicated to making decisions that benefit patient outcomes and the unit’s mission. Strong leaders focus on the situation and not on individuals. The goal is to resolve issues and increase opportunities to move the organization’s mission forward. Leaders should always be courteous and make requests, versus imposing demands. Knowledge is power; leaders should always maintain a current knowledge base to sustain credibility. Finally, leaders should use coercive power strategies only when other methods have failed.

TABLE 11-1: POWER – TYPES, PEOPLE, AND EXAMPLES

<table>
<thead>
<tr>
<th>Power Type</th>
<th>Person</th>
<th>Examples of Specific Power</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charismatic</td>
<td>Dr. Martin Luther King, Jr.</td>
<td>Dr. King was a civil rights leader who inspired others to believe, and fought for equality despite race.</td>
</tr>
<tr>
<td>Coercive</td>
<td>Nurse manager</td>
<td>The manager can withhold approval of vacation time because a staff nurse did not vote in favor of the nurse manager’s recommendation to go from 8-hour to 12-hour shifts.</td>
</tr>
<tr>
<td>Connection</td>
<td>Staff nurse who is the great-niece of the current state governor</td>
<td>The staff nurse uses her influence with the governor (her uncle) to prevent a state ruling (law) in favor of mandatory overtime requirements for nurses.</td>
</tr>
<tr>
<td>Expert</td>
<td>Certified infusion therapist</td>
<td>The infusion therapist is called to start an intravenous (IV) line for a patient with tortuous veins who is receiving chemotherapy.</td>
</tr>
<tr>
<td>Legitimate</td>
<td>Nursing supervisor</td>
<td>A supervisor calls in the operating room team on a weekend for an emergency surgical case. The supervisor has the authority to call in employees based on her position within the organization.</td>
</tr>
<tr>
<td>Persuasive</td>
<td>Representative Lois Capps, RN</td>
<td>A Congresswoman, who also is a registered nurse, introduced the Nurse Reinvestment Act, which addresses the nationwide shortage of registered nurses.</td>
</tr>
<tr>
<td>Referent</td>
<td>Local minister</td>
<td>A minister is asked to serve on hospital and community boards based on his or her reputation.</td>
</tr>
<tr>
<td>Reward</td>
<td>Nurse executive</td>
<td>The nurse executive has many issues at stake and wants a nurse manager’s cooperation on certain issues, so she grants a lengthy vacation for the nurse manager who will chair the professional practice committee.</td>
</tr>
</tbody>
</table>

TABLE 11-2: CREATING A POWER IMAGE

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive interactions</td>
<td>• Values contributions of all individuals &lt;br&gt; • Asks to hear from everyone in the group &lt;br&gt; • Thanks people for their input</td>
</tr>
<tr>
<td>with groups</td>
<td></td>
</tr>
<tr>
<td>Self-worth</td>
<td>• Carries self in a positive and confident manner</td>
</tr>
<tr>
<td>Polished appearance</td>
<td>• Always well-groomed &lt;br&gt; • Dresses in well-pressed, clean clothes &lt;br&gt; • Dresses appropriately for the given work situation</td>
</tr>
<tr>
<td>Good manners</td>
<td>• Always courteous to others &lt;br&gt; • Treats people in all positions within the organization with respect</td>
</tr>
<tr>
<td>Good body language</td>
<td>• Maintains good posture &lt;br&gt; • Uses gestures to facilitate understanding of the spoken word &lt;br&gt; • Maintains eye contact with others when interactions are taking place &lt;br&gt; • Moves (walks) with surety and confidence</td>
</tr>
<tr>
<td>Excellent communication</td>
<td>• Uses voice inflections in speech &lt;br&gt; • Has expanded vocabulary &lt;br&gt; • Speaks with surety and confidence &lt;br&gt; • Uses appropriate grammar &lt;br&gt; • Speaks with a clear, confident voice</td>
</tr>
</tbody>
</table>

Consensus building and risk taking. Empowerment has two different meanings: transfer of power from a manager or supervisor and instilling self-confidence in individual nurses.

In nursing and health care, empowered environments are seen in hospitals that have achieved Magnet status. Nurses are given the authority and resources to make decisions that positively impact patient care.

Power Strategies

Nurses who can see the issues in healthcare organizations and offer different strategies to manage patient care outcomes and develop organizational strategies are viewed by others as being powerful and knowledgeable in their professional field. Organizational strategies may center on changing a policy to effect a needed change such as visiting hours in critical care.

See Table 11-3 for power strategies that facilitate the professional’s place within the organization and also have a powerful impact on organizational outcomes. Powerful nurses:

- handle disruption and conflict in the work unit and do not procrastinate because disruptive behavior takes energy away from the individual and group. An effective person translates conflict into a constructive course of action that benefits the unit and the organization.
- manage negativity when it occurs and avoid larger conflicts, which deplete the energy needed to propel the group forward.
- use the best communication skills possible to resolve conflict and get the group moving forward to achieve its purpose and mission.

Power Guidelines for Leaders

Sullivan (2004) recommends using the least amount of power necessary in any given situation. Strong leaders focus on the situation and not on individuals. Their goal is to resolve issues and incorporate strategies to move their organization’s mission forward. They should always be courteous and make requests, versus imposing demands. Knowledge is power; leaders should always maintain a current knowledge base to sustain credibility. Finally, leaders should use coercive power strategies only when other methods have failed.

Politics in Nursing

Effective use of power and politics in developing strategies requires close analysis of issues facing nurses at the federal, state, and local levels of government (Patronis-Jones, 2007). As the largest group of healthcare professionals, nurses can influence elected politicians to support legislation that impacts patient care and health policy. The American Nurses Association is the largest national professional nursing organization and wields much power over government affairs at the federal level. One of the major issues this group is currently lobbying at the federal level is the Safe Patient Handling and Movement (SPHM) program (U.S. Department of Veterans Affairs, 2010). This program deals with elimination of manual handling for routine care activities, such as lifting, transferring, and repositioning patients. The SPHM program may help reduce back-related injuries for nurses and other healthcare professionals, enhance patient safety, and decrease work-related costs associated with back and neck injuries. Another intense issue that nurses are exposed to is mandatory overtime. Nurses across the country who work in hospitals, long-term care centers, and nursing homes are faced with long practice hours and other results of the nation’s nursing shortage and inadequate staffing. Adverse working conditions have driven many nurses away from bedside nursing. These types of issues are why staff nurses and nurse executives must learn to be politically savvy and become politically active!

Nurses should learn political processes while they are still in nursing school. One way to do this is by becoming a member of the National Student Nurses Association (NSNA), which currently has more than 53,000 student members nationwide, representing prelicensure diploma, associate degree, and baccalaureate nursing programs and also RN...
TABLE 11-3: POWER STRATEGIES

<table>
<thead>
<tr>
<th>Power Strategy</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manage conflict</td>
<td>Differing opinions are common in work groups. Openly address differences and show appreciation of different ideas. Discuss all aspects of the situation that is causing actual or potential conflict and work to achieve group consensus.</td>
</tr>
<tr>
<td>Inspire followership</td>
<td>Look at individuals within the organization who have knowledge and a work ethic consistent with the group. Invite them to participate in your project(s). Grooming others with attributes of a successful group enhances the group’s power and influence.</td>
</tr>
<tr>
<td>Be proactive</td>
<td>Considerable uncertainty exists in healthcare organizations today. A powerful individual or group offers constructive ideas (versus excuses) to make improvements in health care.</td>
</tr>
<tr>
<td>Acknowledge the ideas and work of others</td>
<td>Public recognition of the contributions of the individual is empowering and benefits the group’s purpose.</td>
</tr>
<tr>
<td>Resource acquisition</td>
<td>Dollars are scarce in healthcare organizations. Obtaining a budget to facilitate a program facilitates quality outcomes.</td>
</tr>
<tr>
<td>Become irreplaceable</td>
<td>Be the best at what you (the group) do. In challenging economic periods in health care, this can help you retain your position.</td>
</tr>
<tr>
<td>Sit on organizational committees</td>
<td>Share your knowledge and expertise with others in different units of the hospital. Your ability to influence information gives you power in affecting the decision process.</td>
</tr>
<tr>
<td>Shared consensus with organizational mission, goals, and values</td>
<td>Know and support the organization’s mission, goals, and values. Speak within the framework of the organization. When resources are needed by the group, they are more likely to be supported by the larger organization or administration. Power is enhanced by the group through a shared vision with the organization.</td>
</tr>
</tbody>
</table>
and treatment could significantly reduce fracture rates, thereby generating substantial cost savings, keeping more people in the workplace, and enhancing quality of life.

Do not adopt the attitude that “I am only one person.” Dr. Karen Daley, President of the ANA, advocated successfully for the Federal Needlestick Safety Act in 2010 after being stuck by a needle in a sharps container (PRWeb, 2010). She contracted the HIV and hepatitis C viruses from this injury and has since been a strong advocate for workplace safety.

Knowing the elected state officials is key to influencing health policy matters. Aides for elected officials answer the telephone, correspond with their constituents via e-mail, and frequently keep track of the number of nurses and constituents calling and inform their respective state congressman or state senator. Nurses are a powerful group of people based upon our sheer numbers, and we have a voice. The ANA carefully considers candidates for various offices and will support (financially and through endorsements) those candidates whose demonstrated positions support nursing, up to and including the Presidency of the United States. Nurses must use their voices!

**SUMMARY**

Understanding power is an essential skill for effective nurse leaders. Nurses are in prime positions to influence healthcare standards of practice and public health policy. When power is viewed positively and power bases are enhanced, nurses can speak in one unified voice. Nurses comprise the largest group of healthcare providers in the world. Speaking with one voice enhances healthcare outcomes, maintains the public’s high esteem for nurses, and positions nurses to be at the helm of major decision making that affects health policy. Nurses can have great influence over health policy issues through their work with large professional nursing organizations.

**Answer the self-assessment questions for Chapter 11 at the end of the course.**

**RESOURCES**

- American Association of Critical-Care Nurses
  - http://www.aacn.org
- National Association of Orthopaedic Nurses
  - http://www.orthonurse.org
- National Student Nurses Association
  - http://www.nsna.org
- Oncology Nursing Society
  - http://www.ons.org

**CHAPTER 12: LEGAL ISSUES**

**CHAPTER OBJECTIVE**

After completing this chapter, the learner will be able to apply legal principles to nursing practice.

**LEARNING OBJECTIVES**

After reading this chapter, the learner will be able to:

1. Relate state nurse practice acts to nursing practice.
2. Differentiate between an error of omission and an error of commission.
3. Outline the elements of malpractice.
4. Describe the process of informed consent.
5. Discuss confidentiality, employment laws, and negligence.

**Common Legal Terms**

**Liable:** responsibility for one’s own actions or inactions (Yoder-Wise, 2011).

**Liability:** a person’s actions or words (spoken or written) that caused harm to an individual (Clark, 2009).

**Plaintiff:** person bringing a lawsuit.

**Defendant:** party being sued (can be one or more individuals or a group, such as a physician, nurse, therapist, or hospital).

**OVERVIEW**

Registered nurses (RNs), advanced practice registered nurses (APRNs), licensed practical nurses (LPNs), and licensed vocational nurses (LVNs) must adhere to local, state, and federal laws when providing patient care and supervising employees. Laws in the United States are separated into civil law and criminal law. Licensed nurses, which include RNs, LPNs, LVNs, and APRNs, must follow the nurse practice acts of their states or territories.

Boards of nursing are the governing agencies responsible for nursing practice guidelines. Appointed by the state governor (or elected official in U.S. territories), each state’s board of nursing is authorized to implement and enforce administrative rules and guidelines and other responsibilities outlined in the nurse practice act. This chapter discusses nurse practice acts and legal principles that impact nurses and the delivery of patient care.

**NURSE PRACTICE ACTS**

A nurse practice act is a set of laws established by each state and the four U.S. territories of American Samoa, Guam, Northern Mariana Islands, and the Virgin Islands to protect the public by regulating nursing practice (National Council of State Boards of Nursing, 2011). Nurse practice acts provide the legal foundation for nursing practice. They include the education and licensing requirements for licensed nurses and outline disciplinary procedures and punitive measures for nurses who violate the act. A nurse practice act defines the scope of practice for nurses educated to practice as LPNs, RNs, and APRNs. An RN is a health professional who practices autonomously within the scope of practice defined by his or her respective state or territory nurse practice act. The primary role of the RN is to implement nursing practice through the scientific problem-solving method known as the nursing process, which includes assessing, diagnosing, and planning care for, implementing care for, and evaluating ill or injured patients. The role of patient advocate is a primary responsibility of all RNs.

Nurse practice acts are a form of civil law, also called common law, which regulates the actions of individuals and corporations in a society. In other words, the term divides the relevant area of law into criminal law and other areas of public law. Criminal law involves justice to be determined by a court of law, where fines and prison time can be given.

Nurse managers and nurses practicing in shared governance models should have copies of their state or territory nurse practice act available on their patient care units. Nurse practice acts are available online and can be downloaded by individual nurses for their personal records. Nurse managers must ensure that they and their subordinates apply the legal responsibilities outlined in their nurse practice acts to their daily practice. Additionally, each nurse practice act requires every practicing nurse to have a current license to practice in his or her personnel file.

**BOARDS OF NURSING**

Boards of nursing have two primary responsibilities: They are the governing bodies and have oversight for all aspects of nursing practice in each state or U.S. territory (Yoder-Wise, 2011). A major role of state boards of nursing is to protect the public. Nurses not meeting the requirements of their respective nurse practice acts will not be given licenses to practice by the board of nursing. Nurses may be brought before a board of nursing for many reasons. Some of the common reasons nurses find themselves before a board are practicing with an expired license and having drug or alcohol addictions. Nurses must keep in mind that the board of nursing is not their advocate; rather, it serves to protect the public from unsafe practitioners.

**NEGLIGENCE AND MALPRACTICE**

The American Nurses Association (ANA) has established standards for nursing practice. Specialty nursing organizations and nursing societies also have established standards of practice, practice guidelines, and disease-specific treatment protocols that provide practicing nurses with specific information to guide patient care. The American Association of Critical-Care Nurses, Oncology Nursing Society, and National Association of Orthopaedic Nurses are a few examples of organizations that provide best practice initiatives and patient care guidelines.

Nursing malpractice results when a nurse’s actions (practice) are not in accordance with current standards of practice or the nurse does not correctly anticipate consequences that a professional nurse, having the appropriate skills and expertise, should anticipate. Negligence is defined as a failure to exercise the standard of care that a nurse using ordinary prudence, based on established standards, would exercise under the same or similar circumstances. An example of prudent care would be a nurse double-checking a heparin dosage with another nurse to ensure the correct dosage. If a nurse makes a medication error with anticoagulant medication (administered a wrong dose to the patient or gave medication to the wrong patient) as a result of not double-checking the anticoagulant medication dosage, the nurse has committed a negligent act. Nurses must be prudent in all aspects of patient care delivery. Standard care includes checking the patient’s identification bracelet and using two forms of patient identification before administering a blood product or starting a heparin drip, even if the patient is known to the nurse.

**DOCUMENTATION**

Automated medication administration systems and point-of-care clinical documentation systems have positive results for patient care. These results are made possible because electronic documentation systems are at the bedside or the nurse
has direct access to a computer. Errors are prevented when handwriting is not misinterpreted. Care is documented at the time of occurrence (Mansur, n.d.). Point-of-service bar coding during medication administration helps nurses ensure that the “eight rights,” which include right patient, medication, time, dose, route, documentation, reason, and response, have been followed.

A drawback of automated medical records systems is that they are expensive (Landro, 2002). Changing to a bar code system can cost a healthcare organization an estimated $1.5 billion, and many organizations cannot afford to initiate fully automated systems. Therefore, nurses must complete accurate documentation in the medical record in a timely manner, and their handwriting must be legible. Documentation of care should be done at the time of the occurrence. If called into a court of law, the medical record is viewed as being more objective than the nurse’s verbal recall of an incident or work history.

Errors

An error of omission occurs when a nurse or other healthcare provider does not make a notation in the medical record. Examples include not documenting vital signs, the amount of drainage on a dressing, or medication administration. An error of commission occurs when a nurse or other healthcare provider fabricates information and documents it in the medical record. Examples include charting vital signs, central venous pressure readings, or dressing changes that were not done. These errors have implications for the patient because the care the patient needs is not being delivered and a medical or nursing decision could be made based on false data. At a minimum, the offending nurse or healthcare provider should receive disciplinary action; termination from employment is possible.

Incident Reports

If an untoward event occurs, such as a patient fall or a medication error, the nurse should complete an incident report, which is sometimes referred to as an unusual occurrence report. Incident reports are documents that help analyze problems so that solutions can be formulated to prevent the event from recurring. Depending on the state law, these reports may be recoverable. Some states view incident reports as business reports, which are not part of the medical record. The nurse should not refer to the incident report in the patient’s medical record because it then becomes a part of the record, which means the document can be used in a court of law. By keeping incident reports out of the medical record, agencies can use the information as a quality improvement tool.

Event Reports

Some states have adopted legislation that requires hospitals, outpatient surgical centers, and treatment centers to document when certain serious events occur (Minnesota Department of Health, 2008). These serious, untoward occurrences are documented on event report forms. Examples of serious events that should be documented in this way include performing surgery on the wrong body part, leaving an operative sponge inside of a surgical site, and a patient with Alzheimer’s disease suffering serious harm after eloping from a facility. Each state has different protocols and reporting forms to file when a serious event occurs. Nurses should refer to their state’s Public Health Department rules and regulations to learn the specific requirements.

Event reports are intended to provide data to facilitate the development of interventions that improve patient care. An example are surveillance systems that classify data and determines trends in untoward healthcare occurrences. Data within event reports are transformed into usable information to reduce errors and increase patient protection. Examples of protocols that have been put into place as a result of analyzing information on event reports include, but are not limited to:

- requiring surgical teams to take a definitive break (time out) before the start of each surgical procedure (and in some cases in-between operative cases) to make sure they have the correct patient, identified the correct body part to be operated on, and are planning on performing the correct procedure
- placing identifying colored wristbands or stickers on patients’ doors to classify them as “at risk” for falling or wandering
- using special beds and medical supplies for patients at risk for pressure ulcers

The purpose of event reporting is to determine the causes of untoward events, rather than the number of these events that have occurred. Sharing this information with the healthcare team can facilitate needed changes in healthcare systems and diminish the reoccurrence of untoward events.

**ELEMENTS OF MALPRACTICE**

Six elements of malpractice must be considered (Yoder-Wise, 2011):

- duty
- breach of duty
- foreseeability
- causation
- injury
- damages.

All six elements must be present for a plaintiff to successfully win a malpractice lawsuit. To find a nurse or healthcare organization liable, all six elements of malpractice must be proven in a court of law. Liability refers to a nurse’s responsibility for his or her own conduct, duty to be performed, and responsibility for an action or outcome. The elements of malpractice are reviewed here.

**Duty**

Duty is the first element that is owed to the patient (Klainberg & Dirschel, 2010; Yoder-Wise, 2011). Duty involves a relationship between the nurse and the patient when a care assignment has been accepted. An example of exercising duty is checking a patient’s armband prior to administering a medication. This action represents the standard of care that is the minimum requirement for satisfactory nursing practice. Position descriptions, established standards of practice, a health care agency’s policy and procedure manuals, written protocols, and the nurse’s clinical experience and educational credentials help frame the standards of care.

**Breach of Duty**

Breach of duty is defined as falling below the established standard of care (Klainberg & Dirschel, 2010; Yoder-Wise, 2011). This element is easy to prove when compared with the duty owed. For example, a surgeon ordered that a unit of packed cells be given to a postoperative patient with a low hemoglobin level and hematocrit and the nurse did not administer the blood. This omission is validated through lack of documentation of blood administration and lack of the nurse’s documentation of infusing the unit of packed cells.

Another example of breach of duty is when a nurse takes no action or intervention when a patient complains of chest pain. Most facilities have standing protocols in place for when a patient complains of chest pain. Failing to follow established protocols constitutes a breach of duty. Other nurses are commonly called as expert witnesses in court cases to assist the judge and jury in understanding the standards of care. Nurse expert witnesses testify as to the applicable and acceptable standard of nursing practice and whether, based on the specific case, the standards were followed.

**Foreseeability**

The third element of malpractice is foreseeability, which is described as certain events that are reasonably expected to cause certain specific results. An example of foreseeability is when a nurse is caring for a patient who is obese and within the first few postoperative days. The nurse is aware that the patient needs two nurses to assist with ambulation from the bed to the bathroom, but attempts to help this patient walk by herself and does not request the assistance of another nurse. When the patient falls and sustains a Colles’ fracture, the expert witness testifies in a court of law that the staff nurse should have foreseen the fall. The testimony reflects that another nurse, under the same or similar circumstances, using sound clinical judgment, would have sought the assistance of a second nurse to assist with ambulation or would have left the patient in bed and offered a bedpan.

**Causation**

The fourth element of a malpractice lawsuit is causation, which refers to a direct link between the nurse’s action or inaction and the harm caused to the patient. In the aforementioned scenario, in which two nurses were needed to assist a patient to the bathroom, the nurse’s action to assist the patient by herself directly caused an injury. This is causation because there is a direct link between the injury and the nurse acting below the expected standard of care (in this case, requiring two nurses to assist with ambulation).

**Injury**

The resultant injury (a Colles’ fracture, in this example) is the fifth element of malpractice (Yoder-Wise, 2011). The patient must sustain an injury before a nurse can be found negligent in a court of law. In this scenario, the nurse is liable and malpractice can be found against the healthcare provider (nurse) and the hospital.

**Damages**

The attorney for the injured party must be able to prove damages, the sixth element of malpractice (Yoder-Wise, 2011). Because malpractice is unintentional, damages are vital. In the previous scenario, the patient might show financial harm due to the increased length of hospital stay and extra treatment required for the fracture, which would also add to hospital costs. If the patient is a secretary, for example, lost wages could be recoverable because...
DEFENDING A MALPRACTICE LAWSUIT

The three strategies for defending against malpractice are:
• asserting that the statute of limitations (time frame in which a plaintiff can bring suit against a defendant) has expired.
• comparing fault (charges that the patient contributed to his or her own injury).
• formal denial of allegations (defense attorney argues that the nurse did not do what was alleged in the complaint).

The case study in Box 12-1 presents a potential malpractice situation, in which a patient experienced a fall. The patient’s injuries outlined in the case could lead to a malpractice lawsuit. Another case study, outlined in Box 12-3, presents an example of how a patient may have contributed to his or her own injury. In this particular case, the hospital attorney would defend the lawsuit by claiming that the competent patient caused the injury.

Nurse managers should post current standards of care on their patient care units. All units should post current best practice guidelines from specialty organizations and the ANA. Each nurse is responsible for knowing the information in each standard, and nurses engaged in specialty practice must know what governs or provides evidence to their particular specialty area. Ensuring knowledge of and compliance with current standards of nursing practice can be documented by:
• performance evaluations that state evidence for nursing practice within acceptable standards.
• random chart audits to determine that documentation complies with standards of practice.
• spot audits to determine whether nurses know standards of care for their practice areas and can locate materials on their assigned units.

INFORMED CONSENT

Many years ago, physicians provided direct care with a paternalistic, “father knows best” approach (Ignatavicius & Workman, 2010). They proceeded with the medical plan of care with minimal input from the patient. In the past, patients typically deferred to their physicians for exclusive expert judgment. Today, however, more patients exercise decision-making autonomy relative to their medical care and want to be active participants in their plans of care. The formal concept of informed consent ensures that patients know all of their options relative to medical treatment and care.

Elements of Informed Consent

Four key elements must be present for informed consent to take place:
• competence
• disclosure of information
• comprehension
• voluntariness.

Competence

Competence requires that the person making decisions be able to make them reasonably. The patient should understand the treatment being discussed, be able to differentiate the risks and benefits of the treatment as explained by a physician, and be able to make a decision with the knowledge received.

Disclosure of Information

Disclosure defines the boundaries or amount of knowledge an individual needs in order to make a rational decision. The patient must be apprised of all treatment options.

Comprehension

Comprehension is the ability of the individual to understand what is being explained in order to make a decision. Medical terminology and specific treatments must be explained by a physician.

Voluntariness

Voluntariness requires that a patient make an informed decision, without coercion from others.

Nurse’s Role in Informed Consent

From a purely legal standpoint, a nurse signs an informed consent form only to witness the patient’s signature. If the patient has questions about the proposed treatment or surgical intervention, the nurse should refer the patient to the physician for answers. The physician should disclose all risks associated with a procedure, including surgery, using terms the patient can understand (LeMone & Burke, 2008). Typically, the nurse assists the physician in determining the patient’s level of understanding. The informed consent document protects the patient, nurse, physician, and healthcare institution.

Consent for Mentally Incompetent Persons

A mentally incompetent person cannot provide consent for any treatment. In such cases, healthcare providers can make limited decisions. A person who is mentally incompetent is not able to carry out important decisions about his or her affairs (U.S. Legal, n.d.). Examples might include persons with severe pervasive developmental disorders that would negatively affect mental competence, dementia, Alzheimer’s, unstable schizophrenia, or other disabling chronic psychiatric illnesses. In these circumstances, a court-appointed guardian is given the legal authority to provide consent for treatment for the mentally incompetent person. Often, the court-appointed guardian is a relative who is able and willing to fulfill this role. The court may terminate a guardianship if it is later determined that the need for guardianship no longer exists. In the case of a minor, when the child reaches the age of majority the need for guardianship may be reviewed.

Consent for Emancipated Minors

An emancipated minor is a person who is younger than the age of majority determined by state law. These individuals are viewed legally as being old enough, by virtue of marriage or financial independence, to make adult decisions and have the ability to exercise control over their own lives. The age for emancipated minors varies by state. The medical situations for which emancipated minors commonly seek treatment include substance abuse, communicable diseases, and pregnancy (Yoder-Wise, 2011). However, in many states it is not necessary for minors to be declared emancipated to seek treatment for reproductive issues, sexually transmitted diseases, or outpatient mental health services, including substance abuse. State laws in this regard vary widely, so the learner is encouraged to refer to the laws in the particular state in which he or she practices. Nurses can consult with other members of the healthcare team, such as risk management personnel, human resources, or a safety officer, to answer questions and provide safe care to this cohort.

IMPLIED CONSENT

Implied consent is nonverbal acceptance of a healthcare provider’s request to provide treatment (Law Core, n.d.). A patient action that supports implied consent is walking into a physician’s office for a service such as a physical exam. Because this is a routine procedure, consent is not obtained. Another example of implied consent is when a patient allows a home health nurse to come into the home. Consent is also implied when patients voluntarily request treatment in emergency departments and when the patient presents with an emergent life-threatening illness or injury.

CONFIDENTIALITY

Confidentiality bars disclosure of patient information gained in the nurse-patient relationship to a third party, without the consent of the patient.

<table>
<thead>
<tr>
<th>TABLE 12-1: ELEMENTS OF MALPRACTICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elements</td>
</tr>
<tr>
<td>Duty</td>
</tr>
<tr>
<td>Breach of duty</td>
</tr>
<tr>
<td>Foreseeability</td>
</tr>
<tr>
<td>Causation</td>
</tr>
<tr>
<td>Injury</td>
</tr>
<tr>
<td>Damages</td>
</tr>
</tbody>
</table>
**BOX 12-1: CASE STUDY – MALPRACTICE DEFENSE**

Jane J., a 62-year-old patient, is admitted to a medical rehabilitation unit for gait training and lower extremity strengthening exercises. She has a history of Parkinson’s disease and is married to John, a healthy 65-year-old man.

At 7:00 p.m., Mrs. J. is assisted to the bathroom by her nurse because her gait is unsteady. Two hours later, at 9:00 p.m., she is given 30 mg of Dalmane to help her sleep. Her four side rails are up, as ordered by her physician. At 11:00 p.m., she is assisted to the bathroom again by her nurse. At 3:45 a.m., Mrs. J. is found on the floor and is complaining of severe pain in her right hip. Three of the side rails are up at this time. An X-ray confirms that Mrs. J. has sustained a fractured hip.

During surgery to repair the hip fracture, Mrs. J. has a stroke and suffers brain damage. She was the administrator of a large textile company and can no longer work.

**Discussion Questions**

1. Could a medical malpractice claim be pursued by Mrs. J.?
2. Who may be sued?
3. Who are the potential plaintiffs?
4. Who are the potential defendants?
5. What are the potential damages?
6. Who has a claim for damages?
7. What are the potential defenses to a claim of malpractice?

See Box 12-2 for answers to these questions.

---

**BOX 12-2: ANSWERS TO CASE STUDY – MALPRACTICE DEFENSE**

1. Yes.
2. The nurse, physician, and hospital (the patient typically names as many parties as possible in a lawsuit).
3. The patient, Jane J., and her husband, John.
4. The nurse, physician, hospital, and any other party that the plaintiffs want to name.
5. Cost of extended hospital stay, pain and suffering, loss of income, and loss of sexual relations with husband.
6. The patient, Jane J., and her husband, John.
7. The hospital could assert that the patient was alert and knew to call the nurse for help walking to the bathroom. In this case, the hospital would be claiming that the patient was responsible for, or at least contributed to, her own injury (comparing fault).

See Box 12-3 for answers to these questions.

---

**BOX 12-3: CASE STUDY – COMPETENT ADULT**

A 31-year-old, alert, oriented male is admitted to outpatient services for repair of a left inguinal hernia. He is lying on the gurney, with the side rails up, and has not been medicated. He attempts to throw his pillow and blanket at a certified nursing assistant, who is a neighborhood friend, but accidentally falls off the gurney and fractures his left humerus.

**Discussion Questions**

1. Is the patient liable for his injury? Defend your answer.
2. Is the hospital at fault in this case scenario? Defend your answer.
3. What legal strategy may the hospital assert in defending a malpractice case?
4. If the patient took the hospital to court, who would be the plaintiff and the defendants?

See Box 12-4 for answers to these questions.

---

**BOX 12-4: ANSWERS TO CASE STUDY – COMPETENT ADULT**

1. Yes. The patient is an alert and oriented competent male who was not medicated. The patient engaged in horseplay of his own volition. He is at fault for causing the fractured humerus.
2. No. The patient caused the injury.
3. If the patient took the nurse, physician, or hospital to court, the hospital attorney would formally deny any allegations of causing or contributing to the injury.
4. The plaintiff would be the 31-year-old patient and the defendants would be the nurse, physician, and hospital.

---

(Huber, 2010). The Health Insurance Portability and Accountability Act (HIPAA) was passed in 1996 and was modified in 2002 by the Bush administration to reflect privacy for electronic medical records (Taylor, Lilis, LeMone, & Lynn, 2008). This law protects private, individual health information from being disclosed to anyone without the consent of the individual. The HIPAA Title II act requires the U.S. Department of Health and Human Services (USDHHS) to establish national standards for maintaining electronic health transactions and protecting the privacy of health data (USDHHS, 2000). Hospitals should have in-service sessions for all employees to ensure compliance with HIPAA guidelines. It is also important to provide this information to instructors in schools and universities and their students who practice in health facilities, so that patient privacy is protected.

Patients have the right to access their medical records, and individual states mandate when this right applies. The medical record is a legal document that contains the patient’s health-related information. Documents in the medical record may include operating room checklists and intervention lists on which nurses chart their findings. Some states give patients access to the medical record after documentation is complete, such as after discharge from the hospital. Other states give this right when the patient is hospitalized; therefore, individual state law must govern the nurse’s action. During hospitalization, the nurse should explain entries that the patient questions or requests further information about. If the patient has extensive questions, the physician should be consulted to directly answer the patient questions in a private setting. Patients must give permission for others to access their medical records.

Patients have a right to copies of their medical records. The original records belong to the hospital as a business record, but patients may obtain copies of their medical records at their own expense.

The case study in Box 12-5 highlights the importance of communication among healthcare team members and patients and their families. The significance of keeping patients and their family members informed is reflected in the case study.

**EMPLOYMENT LAWS**

Nurses and nurse managers must be familiar with state and federal employment laws. Potential fears relative to employment laws are allayed when a nurse is knowledgeable about labor legislation and enacted laws (Yoder-Wise, 2011). Knowledge of state and federal labor legislation and laws protects nurses and other healthcare workers in the practice setting.

**Equal Employment Opportunity Laws**

Equal employment opportunity laws have been passed to expand equal opportunity employment prospects for all citizens. Discriminating against an individual based upon race, gender, age, religious preference, disability, pregnancy status, or national origin is prohibited. The Equal Employment Opportunity Commission (EEOC) monitors and enforces employment laws. All states have laws to protect and address the employment opportunities available to individuals.

**The Civil Rights Act of 1964**

The provisions of this Civil Rights Act barred discrimination of individuals on the basis of gender or race in the hiring, promoting, and dismissal from employment processes (National Archives, n.d.). Expanded legislation increased the role of the EEOC and laws that protect individuals from discrimination based upon race, religion, color, gender, national origin, disability, or age, which are called protected classes. Terms and conditions of employment in hiring, promotional opportunities, discharge from employment, wage structures, testing, training, apprenticeship, and all other conditions are monitored and enforced. To ensure fair-
BOX 12-5: CASE STUDY – MEDICAL RECORD

Mrs. Jones is 45 years old and has been diagnosed with Stage III lung cancer. She has been receiving radiation treatment at her local community hospital. Her sister is a nurse who works at the hospital part-time on the obstetrics unit. She is a frequent visitor and is committed to seeing her sister through this medical situation. The patient and her sister have asked several questions, and the nurse has provided factual answers, based on the information that was available; however, the oncologist has not shared all of the information with the staff. Today, the nurse walked into Mrs. Jones’ room and found the patient’s sister reading Mrs. Jones’ medical record. The orderly had inadvertently left the chart in the room after Mrs. Jones returned from her radiation treatment.

Discussion Questions
1. Does Mrs. Jones’ sister have a right to view the medical record?
2. What potential problems may be occurring in this case?
3. In this situation, what should the nurse caring for Mrs. Jones do?
See Box 12-6 for answers to these questions.

BOX 12-6: ANSWERS TO CASE STUDY – MEDICAL RECORD

1. No. The medical record is a legal document.
2. The patient and the patient’s sister (with her sister’s permission) need to receive current information and answers to their questions. The oncologist needs to keep the nursing staff informed, so they can provide the best possible care. Furthermore, the oncologist needs to answer the patient’s questions.
3. Because the medical record was already in the hands of Mrs. Jones’ sister and was being read, the nurse should not jark the record away; rather, the nurse should ask for the return of the record and determine whether Mrs. Jones’ sister read any information that she or her sister did not understand. If the answer is yes, the nurse should be supportive, offer to help, and continue to be honest and factual in her responses. The nurse should call the oncologist or speak to the oncologist during patient rounds, regarding the need to answer Mrs. Jones’ and her sister’s questions. In addition, the nurse can arrange for a patient care conference with the oncologist, nursing staff, dieticians, and all other healthcare personnel involved in the case to facilitate discussion on Mrs. Jones’ current condition and her treatment plan. The nurse must also speak with the orderly to make sure that, in the future, he returns medical records to the nurses’ station (or wherever the medical records are kept). The oncologist should answer any questions and provide information that could assist in Mrs. Jones’ treatment plan as well as in communications with the patient and her family.

Leadership and Management for Every Nurse

ness in the work setting, affirmative action protects the civil rights of designated classes by protecting them from discrimination.

Affirmative Action

Affirmative action differs from policies for equal employment opportunity. Affirmative action policies enhance employment opportunities for the protected classes. For example, federal contractors must ensure affirmative action steps be taken to recruit and hire qualified minorities, disabled persons, and veterans. Furthermore, these steps should be outlined in organizational policies and procedures to ensure the viability of affirmative action programs.

Age Discrimination

The Age Discrimination in Employment Act (ADEA) of 1967 prevents discrimination against older workers. A 1986 amendment to the ADEA specifically protects people older than 40 years of age (Yoder-Wise, 2011). The U.S. EEOC points out that the Act does not protect workers younger than 40 years of age; however, some states have laws that do protect these younger workers from age discrimination. Discrimination also can occur when the victim and the person who inflicted the harm are both older than 40 years of age (U.S. Equal Employment Opportunity Commission, n.d.). It is illegal to harass a person because of age. Comments related to age that are frequent and severe constitute harassment and can contribute to a hostile, offensive work environment.

An example of age discrimination is when a nurse manager is reluctant to hire a nurse in her 50s because the manager thinks the nurse may not be able to work with violent patients who may require restraints. As long as the nurse can perform the essential job functions outlined in a job description, age should not factor into an employment decision.

Americans with Disabilities Act

The Americans with Disabilities Act (ADA) was enacted in 1990 and protects persons with disabilities from discrimination in the workplace. Its protections against discrimination are similar to those in the Civil Rights Act of 1964. Disability is defined by the ADA as a “physical or mental impairment that substantially limits a life activity” (ADA, 2009). This does not include certain conditions, such as a hearing impairment that is corrected by a hearing aid(s).

An RN who is a paraplegic and applies to be an intake nurse for a same-day surgery unit is qualified for the position as long as he or she can perform the role, based upon the job description for the role. In this case, the intake nurse must be able to take a health history, determine laboratory values, take vital signs, and provide patient and family education. Based upon this information, the nurse can perform the essential job functions and is eligible for employment.

In 2008, the ADA Amendments Act (ADAAA) gave broader protections for workers with disabilities, which effectively reversed decisions made by the U.S. Supreme Court that limited the rights of persons with disabilities. The ADAAA requires courts to focus on whether discrimination has occurred, versus whether a person seeking protection from the law has a disability.

The ADA also ensures that work environments allow disabled workers to perform essential job functions. For example, elevators must be available for people to access their work stations. Whereas an able-bodied worker could take the steps to the 4th floor, it isn’t feasible for a person using crutches to do so, if that is the location of the person’s work area.

The learner is referred to Box 12-7 to review a case study for an RN who has a disability and has made application to a coronary care unit. After reading the scenario, answer the questions in Box 12-8, and compare your answers to those provided in Box 12-9.

Equal Pay Act

The Equal Pay Act (EPA) of 1963, which is part of the Fair Labor Standards Act of 1936, is administered by the EEOC. The EPA prohibits gender-based wage discrimination between men and women working in similar positions and in areas requiring equal skill, effort, and accountability. Differences in wages are acceptable when based upon longevity, performance-based merit (salary) increases, and factors other than gender. In the nursing field, the EPA primarily applies to unlicensed assistive personnel.

Occupational Safety and Health Act

The Occupational Safety and Health Act (OSHA) assures safety in the workplace. Nurse managers must be aware of OSHA laws to facilitate a healthful working environment. For example, nurses practicing in an imaging sciences department must be familiar with radiation safety and take precautions during X-ray procedures to prevent unnecessary exposure to radiation.

An area of concern relative to safety is violence in the workplace. Many Emergency Departments (EDs) have security officers stationed in the department to protect healthcare professionals. Nurses, as the largest cohort of healthcare professionals, frequently work short-staffed, which can increase tension in the workplace, thereby making safety an issue of importance in hospitals. Many hospitals employ security officers and station them in the ED to protect healthcare workers, patients, and the public.

Family and Medical Leave Act

The Family and Medical Leave Act (FMLA) of 1993 entitles eligible employees of covered employers to take unpaid, job-protected leave for specified family and medical purposes. Full-time employees may be required by their employer to use all or a portion of their unused vacation, personal leave time, and sick time accrual during the 12-week FMLA. The employee must provide the employer with a 30-day advanced notice of needing to take leave, unless the leave is precipitated by an emergent situation. During the leave, health benefits are maintained as though the employee is still work-
BOX 12-7: CASE STUDY – EMPLOYMENT LAW AND THE AMERICANS WITH DISABILITIES ACT

Jane Doe is a 28-year-old RN who holds a Bachelor of Science in Nursing (BSN) degree and is certified in critical care nursing. She has 6 years of full-time nursing experience: 2 years of practice on a surgical unit, 1 year in an Intermediate Intensive Care Unit (ICU), and 3 years in an ICU. She has had positive annual evaluations during the 6 years she has been employed at the hospital.

Six months ago, Jane was involved in a skiing accident that resulted in a severed spinal cord at T-7, which left her paralyzed. She used time allotted by the Family and Medical Leave Act (FMLA) to recover from her injuries. Jane was discharged in 2 weeks from the acute care hospital and was transferred to a state-of-the-art acute Rehabilitation Unit. An extensive physical therapy and occupational and vocational rehabilitation program was initiated and, within 2 months, she was discharged to her parents’ home. She independently transfers from a wheelchair to her bed and to her automobile. She is able to perform all of her self-care activities.

At this time, Jane wants to return to work at the hospital. The attending physician has signed a release that Jane is ready to return to work. Her full-time position working 11:00 a.m. to 7:30 a.m. in the ICU was posted and filled by another nurse. Jane applied for a full-time position on the 7:00 a.m. to 3:30 p.m. shift in the Coronary Care Unit (CCU).

The CCU nurse manager interviews Jane and determines that she has the knowledge to practice within the CCU; however, her disability would prevent her from responding effectively to emergency situations, which include being on the cardiac arrest “code” team that responds to codes throughout the hospital.

Jane responds by saying that other RNs could serve on the “code” team and respond to emergent situations that would require quickly entering a patient’s room. She cites that she is protected by the Americans with Disabilities Act (ADA) and insists that she be awarded the full-time position.

BOX 12-8: CASE STUDY QUESTIONS – EMPLOYMENT LAW AND THE AMERICANS WITH DISABILITIES ACT

Jane has applied for a full-time position in CCU. She has the required years of experience in acute care, telemetry experience, and holds a BSN degree and certification in critical care by a national certifying body. Included in the essential job functions is the ability for the nurse to respond quickly in emergent situations.

1. Is Jane eligible to return to work based on applicable employment laws?
   Yes _____ No _____
   Explain the rationale for your answer.
   ____________________________________________

2. Can Jane demand to return to her original full-time position in the ICU?
   Yes _____ No _____
   Explain the rationale for your answer.
   ____________________________________________

3. Is the hospital obliged to employ Jane?
   Yes _____ No _____
   Explain the rationale for your answer.
   ____________________________________________

4. The nurse manager in the CCU has approached the Chief Nursing Officer (CNO) about her desire to work with Jane. She would like to offer her a position in the CCU. Can a job offer in CCU be made?
   Yes _____ No _____
   Explain the rationale for your answer.
   ____________________________________________

See Box 12-9 for the answers to these questions.

(leave to care for a covered service person who is seriously ill or injured and who is a spouse, son, daughter, parent, or next of kin to the employee).

The aforementioned guidelines protect workers because their positions (or comparable positions) are held for their return to work.

The FMLA came about primarily because of the large number of single-parent households in which the employee needed job security, without the fear of job loss (Yoder-Wise, 2011). Additionally, employees may care for aging parents and need to take leave to care for them when they become ill. The FMLA was written to balance work life demands with family life demands and to protect the employment status of the worker.

These acts were written to protect the rights of individuals. Table 12-2 gives a succinct explanation of federal labor legislation.

SUMMARY

Nurses must be knowledgeable about the state nurse practice acts for the states or territories in which they practice nursing. Claiming a lack of knowledge of the state or territory nurse practice act is not an accepted legal defense. Being aware of the elements of liability and practicing within the standards outlined in a nurse practice act, along with factual documentation in the medical record, are the best lines of defense in a malpractice lawsuit.

Patient healthcare information is protected by the HIPAA Act of 1996. This act safeguards electronic health record information as well. All employees, including students and their instructors, must be well-versed on the rules addressing patient privacy rights.

Nurses must be knowledgeable of employment laws that affect them and any staff they supervise as well as laws that provide for a safe working environment. Having current employment policies on file and available to all workers increases compliance with employment laws.

Answer the self-assessment questions for Chapter 12 at the end of the course.

RESOURCES

American Association of Critical-Care Nurses
http://www.aacn.org

American Nurses Association
http://www.nursingworld.org

Minnesota Department of Health
Consumer Guide to Adverse Health Events
http://www.health.state.mn.us/patientsafety/publications/consumerguide.pdf

National Archives
http://www.archives.gov/education/lessons/civil-rights-act

National Association of Orthopaedic Nurses
http://www.orthonurse.org

Oncology Nursing Society
http://www.ons.org

U.S. Department of Labor, Wage and Hour Division
Family and Medical Leave Act (FMLA)
http://www.dol.gov/whd/fmla
**TABLE 12-2: FEDERAL LABOR LEGISLATION**

<table>
<thead>
<tr>
<th>Legislation</th>
<th>Explanation Of Legislation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equal Employment Opportunity Law (EEOL)</td>
<td>Encompasses federal laws that prohibit an employer from discrimination based upon age, race, gender, religion, disability, pregnancy, and national origin</td>
</tr>
<tr>
<td>Civil Rights Act of 1964</td>
<td>Protects individuals in the hire and discharge process relative to race, color, religion, national origin, and gender</td>
</tr>
<tr>
<td>Affirmative Action (AA)</td>
<td>Enhances employment opportunities for protected classes of people</td>
</tr>
<tr>
<td>Age Discrimination in Employment Act (ADEA)</td>
<td>Protects older men and women (over age 40) from discrimination by employers, unions, and employment agencies</td>
</tr>
<tr>
<td>Americans with Disabilities Act</td>
<td>Protects disabled individuals in the workplace, relative to access and abilities</td>
</tr>
<tr>
<td>Equal Pay Act of 1963</td>
<td>Protects wage structure based on gender</td>
</tr>
<tr>
<td>Occupational Safety and Health Act (OSHA)</td>
<td>Protects safe and healthful work environments</td>
</tr>
<tr>
<td>Family and Medical Leave Act (FMLA)</td>
<td>Protects employment for single-parent and two-parent households; gender neutral, based on medical and family situations</td>
</tr>
</tbody>
</table>

U.S. Equal Employment Opportunity Commission
Age Discrimination
http://www.eeoc.gov/laws/types/age.cfm

U.S. Department of Health and Human Services,


**Chapter 13: Ethical Principles**

**Chapter Objectives**

After completing this chapter, the learner will be able to discuss ethical dilemmas and the available resources for managing them.

**Learning Objectives**

After reading this chapter, the learner will be able to:
1. Define ethical concepts.
2. Describe ethical dilemmas.
3. Discuss the Code of Ethics for Nurses.
4. Explain how ethical decision-making models and frameworks are incorporated into making ethical judgments.
5. Distinguish the roles of ethics committees and ombudsmen.

**Common Ethical Terms**

- **Moral**: the principle of doing right or good.
- **Nursing ethics**: ethical concerns in nursing practice that nurses must manage with regard to their own actions and interventions.
- **Ethical dilemma**: conflict between two or more ethical principles for which there is no right or wrong decision.

**Overview**

Ethics can be described as a declaration of what is right, what is wrong, and what ought to be. Balancing multiple factors that protect and support individuals as well as the needs of a group or organization often creates a conflict of interest; these ethical dilemmas are increasingly common in health care today. Nurses are confronted with these difficult situations on a daily basis and should use ethical principles to guide patient care. For this reason, nurses should be knowledgeable about ethical principles and proactive in managing difficult situations. The complexity of situations and the multiple players involved require collaboration among healthcare providers and, in difficult situations, should involve professional colleagues, ethics committees, and ethicists.

Ethical concepts are defined and applied to ethical dilemmas in this chapter. The American Nurses Association (ANA) Code of Ethics is provided as an ethical model for the nursing profession. In addition, the roles of ethics committees and ombudsmen are defined and discussed. Ethical decision-making models and frameworks are introduced as working tools to assist in ethical judgments.

**Ethics Defined**

Ethics is a branch of philosophy that distinguishes an action based on values, which are often abstract and difficult to define or generalize to others. Ethics studies what is right or wrong in order to assist individuals in decision making based on knowledge, rather than opinion. Ethics may be mistakenly confused with morality, which is a behavior in accordance with custom or tradition and is usually based on personal or religious beliefs (DeLaune & Ladner, 2011). The goal for the professional nurse is to act morally, based on ethical principles and moral frameworks that guide ethical decision making.

Ethical principles are the foundation of ethics and essential to understanding them. The most common principles are:

- Autonomy
- Beneficence
- Nonmaleficence
- Fidelity
- Justice
- Veracity
- Confidentiality
- paternalism
- Respect for others
- Utilitarianism
- Privacy.

Table 13-1 provides a more inclusive explanation of the common ethical principles. Reflection and experience are necessary to understand many of the ethical principles in the context of health care; examples relative to nursing practice are provided.
The term morality may refer to some codes of conduct as determined by a society, a group, or a religion and must be accepted by an individual for his or her own behavior. Nursing has strong moral roots that evolved from societal needs to preserve humanity by helping one another, specifically by meeting perceived health needs (Burkhardt & Nathaniel, 2008).

Ethical dilemmas occur when there is a conflict between two ethical principles and no clear action is evident. It may also involve situations in which supporting one patient’s ethical principle may impede another patient’s rights. An example is the most basic right to personal freedom, known as autonomy. Although respecting an individual’s right to self-determination appears straightforward, often it is clouded by the needs of another individual or a collective group. A commonly occurring example is provided in the scenario in Box 13-1, which illuminates how one person’s autonomy may impede others’ rights to self-determination. Conflict may also occur when the nurse must choose between respecting an individual’s autonomy and preventing possible self-harm to the patient (see Box 13-2).

Another frequently occurring ethical dilemma involves the principle of veracity, which mandates that the nurse tell the truth. Nurses are ranked as having high standards of honesty and ethics (Jones, 2010); however, the need for truth-telling may conflict with beneficence. At times, a nurse may consider deception morally acceptable, especially when it is done to promote beneficence. See Box 13-3 for a case study in which these two ethical principles conflict. Answers to the case study questions can be found in Box 13-4.

Every patient has the right to privacy. The case study in Box 13-5 provides an example of how patient privacy can produce conflict for a nurse who practices under the principle of utilitarianism.

**TABLE 13-1: ETHICAL PRINCIPLES**

<table>
<thead>
<tr>
<th>Ethical Principle</th>
<th>Definition</th>
<th>Example in Nursing Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Autonomy (freedom)</td>
<td>Personal freedom; the right to self-determination</td>
<td>A patient chooses to accept or reject a recommended treatment plan.</td>
</tr>
<tr>
<td>Respect for others</td>
<td>Acknowledgement of an individual’s right to make his or her own decisions and live by them</td>
<td>The nurse accepts the patient’s decision, although it is not the recommended course of action.</td>
</tr>
<tr>
<td>Beneficence</td>
<td>Do good; actions should promote the patient’s welfare</td>
<td>A nurse protects and defends the rights of a person with a mental health disability.</td>
</tr>
<tr>
<td>Nonmaleficence</td>
<td>Do no harm</td>
<td>A nurse does not administer an ordered medication when a potential negative consequence is suspected (allergy or adverse reaction).</td>
</tr>
<tr>
<td>Fidelity</td>
<td>Being faithful to your promise or word</td>
<td>A nurse followed through on obtaining a list of low-sodium foods for a patient.</td>
</tr>
<tr>
<td>Veracity</td>
<td>Truth-telling</td>
<td>A patient asks if a procedure will hurt and the nurse truthfully explains any potential discomfort.</td>
</tr>
<tr>
<td>Confidentiality</td>
<td>Privacy of information, including the medical record</td>
<td>Patient medical records are secured so they can be accessed only by persons who need to see them.</td>
</tr>
<tr>
<td>Justice</td>
<td>Fairness and equality in treatment</td>
<td>Patients receive the same level of care, regardless of race, religion, or payer status.</td>
</tr>
<tr>
<td>Paternalism</td>
<td>Interfering with a person’s freedom for his or her own good</td>
<td>The nurse restrains a trauma victim who is intubated and receiving positive-pressure ventilation to prevent the patient from dislodging the endotracheal tube.</td>
</tr>
<tr>
<td>Utilitarianism</td>
<td>Philosophy based on the “greatest good”; asserts that the needs of the many outweigh the needs of the one</td>
<td>A community chooses to pay for flu shots for every child and elderly in the community, instead of paying for one kidney transplant.</td>
</tr>
<tr>
<td>Privacy</td>
<td>Protection of one’s solitude; the right to be left alone</td>
<td>The patient requests to have no visitors throughout the course of hospitalization.</td>
</tr>
</tbody>
</table>

**BOX 13-1: PERSONAL INSIGHT SCENARIO ONE**

Mr. D., an 86-year-old male who resides in a long-term care facility, enjoys watching television late into the night. He states that he has always been a “night-owl” and simply cannot fall asleep early. His habit has long been to fall asleep late at night with the television on. He has a hearing deficit and turns the volume on the television up quite loud. Residents in the rooms surrounding him complain that his TV is interfering with their rest. The nurse discusses this with Mr. D., explaining how it is bothering the other residents and requests that he turn it off at 10 p.m. Mr. D. remains adamant that he is miserable without his television on at night and that it is his right to have his private television on in his private room. Despite efforts to either turn the television off, or at least lower the volume, Mr. D. gets up and sets it to his desired volume.

This scenario is a common one and pits autonomy and self-direction against utilitarianism that considers the needs of a group. If you were the nurse caring for Mr. D in the long-term care facility, what would you do?

**BOX 13-2: PERSONAL INSIGHT SCENARIO TWO**

Consider the following scenario and think about what you would do.

Mrs. T., a 78-year-old woman who resides in a long-term care facility, has insulin-dependent diabetes. She frequently requests candy or asks visitors to bring her candy. The nurse explains the reasons why she should not eat high-carbohydrate foods such as candy, and offers her a low-carbohydrate supplement drink. Mrs. T. listens patiently and then says she understands but does not care about the consequences, citing her advanced age and health. She states, “Honey, at my age there isn’t a lot to look forward to, and even if it could kill me, I don’t care. I want candy.” The nurse assesses Mrs. T.’s capacity to make this decision and her understanding that eating the candy may cause her harm. Although this may violate beneficence, Mrs. T. understands the risks and is competent to make the decision. Should the nurse respect Mrs. T.’s right to self-governance and allow her to eat the candy? If you were the nurse caring for Mrs. T., what would you do?

Answers to the discussion questions are provided in Box 13-6.

Ethical dilemmas frequently are associated with confusion between opinions or personal beliefs and knowledge. Nurses must understand ethical principles to begin to unravel ethical dilemmas that can occur in practice. Knowledge, personal reflection, and experience can help seasoned nurses guide novice nurses in issues involving ethical concerns. To make informed decisions, nurses must examine their own personal values, which are the internal forces that influence decision making and priority setting (Yoder-Wise, 2011). An individual’s values are freely-selected abiding beliefs about the worth of something, whether it relates to a person or concept (Finkelman, 2006) Values influence the decisions of physicians, patients, and their families as well as nurses.

Moral distress is a term used to describe the anxiety that occurs when nurses experience situa-
BOX 13-3: ETHICAL CASE STUDY – FREEDOM AND VERACITY

Elisa is 11 years old. She has a history of bed-wetting (enuresis). Elisa has asked Carolyn, her nurse, not to tell her parents and Carolyn has agreed. Elisa’s parents may be overly concerned with her bed-wetting. When the parents visit the hospital, they ask Carolyn if Elisa has been wetting the bed. If Carolyn tells them the truth, this is in line with the ethical principle of veracity. However, telling the truth could interfere with the good interaction between Elisa and her parents because it would interfere with the actions Elisa wants to take in not informing her parents of her continued bed-wetting. Carolyn does not know if the parents will be understanding or if they will be unsympathetic. In order to facilitate Elisa’s freedom of action in not informing her parents of her continued bed-wetting, the nurse would have to remain silent or practice deception.

This case is a true reflection of an ethical dilemma: Two ethical principles, freedom and veracity, are in conflict. One ethical principle requires the nurse to facilitate her patient’s freedom of action. Another places a moral obligation on the nurse to tell the truth.

Discussion Questions
1. Define freedom and veracity.
2. What would you do if you were the nurse in this situation? Why?
3. Ethically, can deception be employed in this case study? Defend your answer.
4. What resources can the nurse in this scenario consult to help her resolve this ethical dilemma?

See Box 13-4 for answers to these questions.

BOX 13-4: ANSWERS TO ETHICAL CASE STUDY – FREEDOM AND VERACITY

1. Freedom is an individual’s right to make choices about his or her healthcare options. Veracity is telling the truth.
2. Depending on the values of the individual nurse, this question could be answered in many different ways. Carolyn could choose not to agree with Elisa and tell the parents of the bed-wetting occurrences. She could also remain silent or practice deception by lying about the bed-wetting.
3. Yes; however, the nurse’s value system would have to reconcile that deception is morally acceptable with the objective of upholding beneficence.
4. The nurse should realize she is not alone and discuss the situation with the patient’s physician to ensure that Elisa’s parents do not need to be made aware of a pending health issue. The ethics committee can also be consulted for clinical situations that present ethical dilemmas.

BOX 13-5: ETHICAL CASE STUDY – UTILITARIANISM AND PRIVACY

Lynnette is in the hospital. She is a 47-year-old woman who has metastatic breast cancer and does not want her family to know that she is at the end-of-life and is dying. Lynnette has low energy, and her fatigue level now taxes her coping mechanisms, which are normally excellent; she does not feel that she can deal with her family’s grief.

Lynnette’s daughter has been discharged from the Air Force and is returning home from an overseas deployment. The family has planned a surprise party for Lynnette in the hospital when her daughter arrives back home and has invited many of her friends and family members.

Lynnette’s nurse is conflicted because she practices under the principle of utilitarianism and is aware of her patient’s desire for privacy as well as the party planned by the family. Lynnette does not know about the party and her family does not know about her prognosis.

Discussion Questions
1. Define utilitarianism and privacy.
2. What would a person of utilitarian thought do in this case?
3. What about the unwritten nurse-patient agreement as it relates to beneficence?
4. How does this pose a conflict for a nurse practicing the ethical principle of utilitarianism?

See Box 13-6 for answers to these questions.

BOX 13-6: ANSWERS TO ETHICAL CASE STUDY – UTILITARIANISM AND PRIVACY

1. Utilitarianism is the “greatest good” theory: providing the greatest good to the greatest number of people. Privacy is an individual’s right to keep information about one’s self from being disclosed.
2. A nurse employing the principle of utilitarianism would tell the family that Lynnette is dying. The family comprises a “greater number” than Lynnette as one individual.
3. This is the true nature of this ethical dilemma because beneficence requires the nurse to do good and honor Lynnette’s request.
4. The ethical dilemma is that the two ethical principles of utilitarianism and privacy are in conflict. Different nurses, depending on their personal value systems, may choose different ways to manage this ethical dilemma. In either case, further discussion with the patient is indicated to see if a satisfactory solution can be reached.

Box 13-6: ANSWERS TO ETHICAL CASE STUDY – UTILITARIANISM AND PRIVACY

4.	What	does	this	pose	a	conflict	for	a
nurse	practicing	the	henethical
t
t
principle	of
t
utilitarianism?

3.	What	about	the	unwritten	
nurse-patient	
tagreement	as	it	relates
to
beneficence?

2.	A
nurse	employing	the
principle	of	utilitarianism	would
tell	the
family	that	Lynnette	is
dying.
The
family	comprises	a	“greater	number”
than	Lynnette	as
e

1. Define utilitarianism and privacy.

1.	Utilitarianism	is	the	“greatest
good”
theory:
providing	the
greatest
good
to	the
greatest
number
t
people.
Privacy	is	an
individual’s
right
to
keep
information
about
one’s
self
from
being
disclosed.

2. A nurse employing the principle of utilitarianism would tell the family that Lynnette is dying. The family comprises a “greater number” than Lynnette as one individual.

3. This is the true nature of this ethical dilemma because beneficence requires the nurse to do good and honor Lynnette’s request.

4. The ethical dilemma is that the two ethical principles of utilitarianism and privacy are in conflict. Different nurses, depending on their personal value systems, may choose different ways to manage this ethical dilemma. In either case, further discussion with the patient is indicated to see if a satisfactory solution can be reached.
Jana, a new graduate nurse, cared for her mother during a terminal illness of lung cancer. Her mother was a heavy cigarette smoker, which was most likely a contributing factor to the disease. Jana, a nonsmoker, hated the smell of smoke and was an outspoken advocate for smoking cessation. While caring for J.W., a 58-year-old male with chronic obstructive pulmonary disease (COPD), Jana was aware that he left the nursing unit several times during her shift and returned smelling of cigarette smoke. She addressed this observation with J.W., provided education on the risks of smoking, and offered smoking cessation information. Initially J.W. denied smoking, but later admitted that he was going outside to smoke. He stated that he liked smoking, understood the risks, and did not want to stop smoking. Agitated, he told Jana to mind her own business and just take care of him like she was supposed to. Jana was distraught and confided to a coworker that she didn’t think she could care for J.W. anymore because he wouldn’t accept her knowledge and help, and she knew more about the devastating effects of tobacco use than he did.

How would you react in this situation? Could you set aside your personal beliefs and care for the patient, or would you impose your decision on the patient?

The Ethical Positioning System Model (Kelly, 2012). The difference in this model is a step that requires applying the ANA Code of Ethics to the data being examined. The key points of this model are:

- Assessment: includes gathering data and identifying all players involved as well as the context of the situation.
- Ethical dilemma: refers to a statement that defines the problem and ethical conflict.
- Planning: all pros and cons are examined and compared to the ANA Code of Ethics for Nurses with Interpretive Statements (2001) to make a choice.
- Develop a visual image of the planning process: this is recommended to provide a visual of the pros and cons and to aid in eliminating choices.
- Implementation of the final choice.
- Evaluation: includes examining the outcome, what worked, and what was learned.

Some strong parallels exist between the American Medical Association (AMA) Code of Ethics and the ANA Code of Ethics for Nurses (Allhoff, Jarosch, Matiasek, Reenan, & Wynia, 2006). The AMA Code of Ethics, also adopted by their House of Delegates in 2001, includes the responsibility to the patient, concepts of competency, respect for human dignity, and the rights of patients, colleagues, and other health professionals. Similar to the ANA Code of Ethics for Nurses, the AMA Code describes the sharing of information and participation in continuing education as elements of ethical practice. Participation in activities to improve communities and public health are aspects that also are included. (AMA, 2001) The framework, Improving Communication – Improving Care, was written by the AMA’s Ethical Force Program (2006) and emphasizes the importance of communication in the provision of ethical care. Some of the elements of this framework that speak to communication as an important aspect of ethical practice are:

- Engage patients, including those from vulnerable populations, through quality interpersonal communication that effectively elicits health needs, beliefs, and expectations; builds trust; and conveys information that is understandable and empowering.
- Consider the sociocultural context in providing respectful care to populations with diverse backgrounds; this includes helping other members of the workforce to understand the sociocultural factors that affect health beliefs and the ability to interact with the healthcare system.
- Make language assistance easily available if needed to communicate effectively with the patients or populations to be served, and educate the workforce to access and use language assistance resources.
- Determine the health literacy level of the patient or potential population and use this information to develop a strategy for the clear communication of health information verbally, in writing, and through the use of other media. Patients must be given health information appropriate to their health literacy level. Nurses must ensure that verbal instruction and teaching, written instruc-

### TABLE 13-2: CODE OF ETHICS FOR NURSES

1. The nurse, in all professional relationships, practices with compassion and respect for the inherent dignity, worth, and uniqueness of every individual, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems.
2. The nurse’s primary commitment is to the patient, whether an individual, family, group, or community.
3. The nurse promotes, advocates for, and strives to protect the health, safety, and rights of the patient.
4. The nurse is responsible and accountable for individual nursing practice and determines the appropriate delegation of tasks, consistent with the nurse’s obligation to provide optimum patient care.
5. The nurse owes the same duties to self as to others, including the responsibility to preserve integrity and safety, to maintain competence, and to continue personal and professional growth.
6. The nurse participates in establishing, maintaining, and improving healthcare environments and conditions of employment that are conducive to the provision of quality health care and consistent with the values of the profession through individual and collective action.
7. The nurse participates in the advancement of the profession through contributions to practice, education, administration, and knowledge development.
8. The nurse collaborates with other health professionals and the public in promoting community, national, and international efforts to meet health needs.
9. The profession of nursing, as represented by associations and their members, is responsible for articulating nursing values, for maintaining the integrity of the profession and its practice, and for shaping social policy.


**patients and her or his actions on each patient’s behalf.** From an ethics perspective, it is made clear that the nurse’s primary responsibility is to the patient, whether the patient is an individual, family, or community. These three statements provide a foundation for the nursing role.

**Statements four and five describe the broader responsibilities the nurse has for the provision of nursing practice. Accountability is clear in these statements, including the appropriate delegation of tasks and, on a more personal level, the necessity for the nurse to maintain competence. A commitment to personal and professional growth is also recognized as an element of ethical practice.**

**Statements six and seven describe the ethical obligations of nurses to participate in actions beyond the care of individual patients or families.** These statements seem particularly relevant for nurse leaders because they encourage actions that have a broader influence in establishing conditions in which good patient care can occur. The importance of nursing contributions beyond one’s own work environment is presented as an ethical responsibility of nurses.

**Lastly, statements eight and nine urge nurses to fulfill the ethical charge to meet the health needs of the public through collaboration with other health professionals, while also contributing to the nursing profession through membership in professional nursing organizations. Statement nine also expresses the importance of nurses’ roles in shaping social policy as an ethical consideration.**

**Nursing leaders, or nurses who are preparing themselves for leadership roles, must be especially attuned to the directions established in the ANA Code of Ethics for Nurses because the nine statements are essential for ethical nursing practice.**

**Decision-making tools assist the nurse in making ethical decisions, and the use of the five-step nursing process can help with the resolution of issues. Burkhardt and Nathaniel (2008) offer a five-step process, analogous to the nursing process, to assist nurses in making ethical decisions. The steps are defined as:**

1. State the problem succinctly.
2. Assemble data and state the conflicts identified.
3. Consider all strategies and choose a course of action.
4. Implement the strategy.
5. Evaluate the outcome.

**Another model that parallels the nursing process was developed by Joan Dorman and is titled:**...
tions in educational tools and brochures, and media communications are understandable for patients. Assessment of patient understanding of health information is important (American Medical Association, 2006).

Nursing management and other nursing leaders can help to integrate these principles in the settings in which they practice.

### Patient-Centered Communication

As described previously, nurse leaders must initiate and support improved patient-centered communication programs with ongoing outcome measurements. Nurses must be committed to promoting patient rights, serving as advocates for patient health issues, and guaranteeing safety as requisite proficiencies for leaders. These measures can ensure improved patient communication.

### Cultural Considerations

We live in a multicultural world. To communicate effectively with patients and provide ethical, informed, and high-caliber health care, nurses must be aware of each patient’s cultural beliefs, especially as they relate to health, values, language, and communication patterns, and literacy level (Badzek, 2006). Having a theoretical framework can guide healthcare providers and institutions in improving patient-centered communication.

Interpreters are knowledgeable persons who understand regional dialect and can greatly improve patient communication. Understanding a person’s uniqueness, unrestricted by social consideration, socioeconomic status, and personal characteristics, with equitable treatment is at the core of nursing practice.

**MORAL MODEL OF ETHICAL DECISION MAKING**

Developed by Crisham (1985), the MORAL Model of Ethical Decision Making incorporates the nursing process and bioethics. Bioethics are ethics applied in the health professions and include such issues as end-of-life decisions and abortion (Finkelman, 2006). The MORAL model is used when nurses encounter conflicting obligations. The model encompasses five steps, represented by the mnemonic MORAL:

- **M**: Massage the dilemma. Collect relevant data about the ethical circumstance and determine who in the organization should be involved.
- **O**: Outline available options. Identify alternatives and the impact and consequences of each.
- **R**: Review criteria and resolve. Options must be weighed against values and practical considerations. This evaluation can be easily accomplished by placing the options on a decision-making grid (see Chapter 4).
- **A**: Affirm position and act. This step involves developing and implementing the strategy.
- **L**: Look back. Evaluate the decision-making strategy.

In the first step of the model, the nurse must be aware that an ethical dilemma exists. Collecting data about the ethical conflict solidifies the existence of a problem and helps determine who should be involved in the resolution of the ethical dilemma. Health team members must remember that conflicting values of the patient, nurse, physician, and family may occur. An ethical dilemma exists because there are reasons to do two opposing actions.

Outlining options, the second step of the MORAL model, must be done with staff involvement. Available options are weighed against the consequences of the proposed action. They may involve:

- doing nothing.
- scheduling a family conference.
- consulting the ethics committee.
- consulting with an external party, such as an ombudsman.
- referring to the attending physician.

The third step of the model is to review criteria and resolve. To determine a course of action, the options generated in step two are weighed against practical considerations and the primary values of those involved in the dilemma. This evaluation can be accomplished by placing the aforementioned criteria on a decision-making grid. The pluses (+) and minuses (−) in the squares of the decision-making grid quantify the difficulty of the situation. An ethics committee or an ombudsman can count the pluses and minuses and make a decision based on the numerics. With a situation as difficult as an ethical dilemma, this mechanism helps to quantify the available options and make them more objective. An example of an ethical decision-making grid (matrix) is seen in Table 13-3, which shows how difficult ethical decisions can be made quantifiable.

The fourth step of the model is when the nurse and health care team confirm a decision and intervene. Several questions by nurses and other team members may surface in this step, such as:

- Are nurses and team members free to state their opinions without consequences?
- Will physicians agree with the interventions recommended by the team?
- Should the team have consulted with an outside party, such as an ethics expert who is not employed by the hospital?

### Ethics Committees

The increasing complexity of the healthcare world – the technology explosion in the computer age, new treatment innovations, and an aging society experiencing greater longevity – creates a higher incidence of ethical dilemmas. Healthcare agency-based ethics committees provide long- and short-term assistance, education, policy development, case review, and consultation services to nurses and other healthcare professionals (Finkelman, 2006). Ethics committees should be open to referrals from the entire hospital community and serve as advocates for patients.

Ethics committees must have widespread professional representation. Committee composition can include nurses and physicians representing different specialty areas. Additionally, hospital chaplains, dieticians, pharmacists, executives, legal representatives, ethicists, and social workers can bring a breadth of knowledge to such groups. After a committee is established, patients and their families can consult the committee for guidance in dealing with ethical dilemmas.

### TABLE 13-3: ETHICAL DECISION-MAKING GRID

<table>
<thead>
<tr>
<th>Options</th>
<th>Freedom</th>
<th>Veracity</th>
<th>Beneficence</th>
<th>Parental Considerations</th>
<th>Clarity of Issue</th>
<th>Legal Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do nothing</td>
<td>−</td>
<td>−</td>
<td>−</td>
<td>−</td>
<td>−</td>
<td>−</td>
</tr>
<tr>
<td>Discuss with physician</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>−</td>
<td>+</td>
<td>−</td>
</tr>
<tr>
<td>Discuss with ethics committee</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>−</td>
<td>−</td>
<td>−</td>
</tr>
<tr>
<td>Schedule a patient care</td>
<td>−</td>
<td>−</td>
<td>−</td>
<td>−</td>
<td>−</td>
<td>−</td>
</tr>
</tbody>
</table>

- Can the nurses and team members reconcile significant differences in their personal values with those associated with this ethical dilemma?

The last step in the MORAL Model is evaluation. The nurse reviews all actions taken to resolve the ethical dilemma. If actions taken have remedied the situation, the nurse and ethics committee can move on to resolve other issues. If the ethical dilemma being evaluated was not resolved, the team restarts the process by returning to step one.

The ANA Code of Ethics for Nurses, the nursing process, the five-step model offered by Burkhardt and Nathaniel, the Ethical Positioning System Model, the MORAL Model, and the Improving Communication – Improving Care framework developed by the AMA can all act as guides for ethical communication and decision making. Nurses learn and base decisions on the conceptual frameworks from their education (Cameron, Schaffer, & Park, 2001). Evidence shows that an overwhelming majority of student nurses who used an ethical decision-making model found that the model was helpful in conflict resolution.

**ETHICS SUPPORT**

Hospitals, nursing homes, long-term care (LTC) centers, home healthcare agencies, hospices, and other health-related institutions must have systems in place to assist in managing actual and potential ethical dilemmas. Most often, hospitals have established ethics committees. In other healthcare institutions, the services of ombudsmen are employed.

- **Do nothing.**
- **Discuss with physician.**
- **Discuss with ethics committee.**
- **Schedule a patient care conference.**
lies should be included as active participants in their care delivery decisions.

In large, urban, teaching medical centers, ethics rounds are made routinely. It is imperative that bedside nurses participate in rounds because they are with patients for the greatest length of time, know patient and family concerns, and act as advocates and catalysts between patients and their primary care physicians.

Ombudsmen

The services of ombudsmen are employed in some healthcare organizations, especially home health care, sub-acute centers, and hospices (Finkelman, 2006). Over 30 years ago, the U.S. Congress mandated LTC ombudsman programs (LTCOPs) for institutionalized senior citizens that included regulations for nursing home residents (Estes, Zulman, Goldberg, & Ogawa, 2004; Miller, 2009; Nelson, Netting, Huber, & Borders, 2004). Through extensive use of volunteers, LTCOPs have revolutionized the LTC industry by resolving thousands of complaints levied against LTC centers.

Populations who reside in LTC centers are frequently aged and considered a vulnerable population. They may not be able to advocate for themselves because of their ages, limited resources, and physical or mental impairments. (Hindle, 2008).

Ombudsmen are people who advocate for patients in LTC centers and nursing homes. They visit residents, hear their issues, monitor their care and living conditions, and protect their rights. Ombudsmen’s roles include improving each patient’s chance for fairness, due process, and individual choice (Persson, 2004). The vast majority (90%) of ombudsmen are volunteers. They view their roles as therapeutic supporters and welcomed visitors who provide emotional support to residents.

ETHICAL AND LEGAL ISSUES

Ethics are considered a higher standard, whereas laws are viewed as the minimum standards of conduct. Laws do not define what ought to be done; they define what must be done to avoid punishment. Although the nursing profession strives for higher moral or ethical principles, nurses are held accountable for legal requirements under penalty of law. Understanding the rights of the patient is necessary to comply with legal mandates. The confidentiality of personal health information is an example of upholding the ethical principle of confidentiality.

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 includes privacy and security rules that protect the privacy of individually identifiable health information (U.S. Department of Health & Human Services [USDHHS], n.d.). HIPAA sets national standards for the security of protected electronic health information, and the confidentiality provisions of the Patient Safety Rule protect identifiable information that is being used to analyze patient safety events and improve patient safety (USDHHS, n.d.). The purpose of HIPAA is to protect personal health information and apply patient rights to that information. The Privacy Rule within HIPAA is balanced so that it permits the disclosure of personal health information needed for patient care and other important purposes within defined guidelines. Failure to comply may result in the imposition of civil monetary penalties.

Protection of confidential private information is not exclusive to health care. Students are also protected and nursing educators must be aware of student rights. The Family Educational Rights and Privacy Act (FERPA) is a Federal law that protects the privacy of student education records. The law applies to all schools that receive funds under an applicable program of the U.S. Department of Education. Under FERPA, student educational records are considered confidential and may not be released without the written consent of the student. An institution’s failure to comply with FERPA may result in the Department of Education withdrawing federal funds. Educational records include, but are not limited to: class schedule, grades, grade point average, academic standing, test scores, academic transcripts, student employment, class lists, and email distribution lists. Educational records may be in paper or electronic files.

Social media is an area of increasing concern for inappropriate dissemination of private information in today’s electronic world. Described as forms of electronic communication in which users participate in online communities to share information, ideas, personal messages, and other content (such as videos), social media is widespread globally. Examples of social media include Facebook, Twitter, and MySpace. Of concern to the professional nurse leader is any violation (whether intentional or unintentional) of personal rights. Consider the following:

Alice, a senior nursing student, uses her cell phone to snap a picture of John (a fellow nursing student) standing next to the bed of a patient in the critical care unit who is being ventilated with an endotracheal tube in place. The patient is visible, though not clearly identifiable in the picture; however, the photo captures the room number, which is clearly visible. Alice uploads the picture to her Facebook account with a message, “Our first day in critical care at XYZ hospital!”

Although this may sound (and was intended to be) innocent, anyone who knew the patient was in that room, on that day, in that hospital, now has a picture of him or her that should be private. Although unintentional, this is a clear violation of patient privacy and HIPAA standards because it was disseminated through social media. The nurse leader should be aware of ethical and legal ramifications of such actions and communicate policies to staff members as well as advocate for continuing education on protecting patient privacy.

COMMON ETHICAL ISSUES FOR NURSES

Nurses are confronted on a daily basis with difficult situations. Ethics committees and ombudsmen can provide guidance and support for many of the situations commonly encountered by nurses, including:

• distribution of nursing staff to meet patient needs
• equitable allocation of resources
• end-of-life decisions and application of advance directives
• confidentiality and electronic charting
• health literacy of different constituent groups
• organ donation and organ transplantation
• gender selection
• abortion
• career rationing
• guardianship (mental impairments)
• incompetence of another nurse or care provider
• issues having to do with an impaired nursing colleague
• questions related to reporting a colleague.

Nurse managers are responsible for supporting staff nurses who provide care for patients with complex health problems that pose ethical concerns. A primary concern of nurse managers is balancing quality care delivery with finite fiscal resources and maintaining ethical standards of nursing practice. Successful nurse managers use ethical principles and the resources of the organization, such as ethicists and ethics committees, to ensure the use of ethical principles for decision making in practice settings.

ETHICAL CASE STUDY

Ethical dilemmas are never easy for nurses. However, reviewing similar situations and how they were managed can help nurses and other healthcare professionals manage future ethical conflicts. The personal insight scenarios and the case study in Box 13-3 bring issues that impact nursing practice everyday to the forefront.

SUMMARY

Nurses must be knowledgeable about ethical principles and be in touch with their own personal value systems. Support systems, such as ethics committees, ombudsmen programs, and agency-employed ethicists, can assist with making difficult ethical decisions. Using a model to guide ethics committee decision making is helpful because it assists in keeping the process objective and non-emotive. If an organization does not employ an ethicist on staff, it can hire one as a consultant when circumstances dictate a need. Nurses, acting as advocates for patients, must tap into all available resources to practice ethically and best serve the interests of patients.

Answer the self-assessment questions for Chapter 13 at the end of the course.

RESOURCES

American Association of Colleges of Nursing
www.aacn.nche.edu

American Hospital Association
www.aha.org

American Medical Association’s Communication climate assessment toolkit (C-CAT) framework

American Nurses Association
http://www.nursingworld.org

National Council of State Boards of Nursing
http://www.ncsbn.org

National Institutes of Health
www.nih.gov

National League for Nursing
www.nln.org

The Joint Commission
http://www.jointcommission.org
CHAPTER 14: NURSING ROLES

CHAPTER OBJECTIVE
After completing this chapter, the learner will be able to describe the various roles of the nurse and the ways in which these roles facilitate change.

LEARNING OBJECTIVES
After reading this chapter, the learner will be able to:
1. Describe the transition process for changing roles.
2. Define the role of the nurse as a mentor, preceptor, and coach.
3. Describe the relevance of a professional portfolio and its components.

OVERVIEW
Over the course of a nurse’s career, he or she may transition in and out of many different professional roles. The first (and often most difficult) transition a nurse makes is from student nurse to licensed nurse. Converting to a professional nursing role after the completion of formal education can be eased by formal nurse mentor programs.

Transitioning – whether from a staff nurse to a nurse manager role, from a hospital clinical nurse specialist to a nurse educator position in a university’s school of nursing, or from a staff nurse to an office nurse – requires that the nurse be coached and mentored into the new role. Transitional periods can be exciting and challenging for the nurse, provided that adequate support systems are in place to support the role change.

Health care is in a constant state of change, and the environment can be tumultuous (Yoder-Wise, 2011). Mergers, acquisitions, workforce reductions, and healthcare agency closures are becoming more commonplace. In such cases, nurses may grieve when a position is lost because of the merging of two hospital units, position descriptions are revised, or nurses are terminated. Change is not easy and can sometimes be complex and illogical. Even when change is the result of an individual’s choice, it still can be difficult (Huber, 2010).

The purpose of this chapter is to look at the special roles of coach, mentor, and preceptor and determine how these roles can facilitate transitions in the nursing profession. Additionally, the importance of grooming new nurses to be future leaders will be explored.

ROLE TRANSITION
Nurses fulfill many different roles over the course of their careers. Role transition involves changing one’s professional distinctiveness. The nursing student role is very clear: Student nurses follow a prescribed curriculum, have clinical and didactic course objectives clearly written in course syllabi, and have handbooks that guide their actions (Crosby, n.d.). A new graduate nurse has experience as a student, with no professional nursing background. This role transition is not clear cut and involves a learning curve from novice to expert (Benner, 2001).

Orientation programs, adequate patient-to-nurse staffing ratios, and programs that help students transition from school to professional practice are critical components for retaining new nurses (Scott, 2005). Experienced, exemplary nurses must serve as role models for new nurses (Miller, 2006). A practicing nurse who performs the professional role in a positive way provides guidance to new nurses.

The staff nurse who transitions into a management role must learn to move from the role of caring for patients, to the role of leading a group of employees. The new manager role includes being a leader, a manager, and a follower (Yoder-Wise, 2011). As a leader, the new manager must listen, encourage, and motivate his or her peers. As a manager, one must organize, budget, and evaluate peers. As a follower, the manager must respect the authority of others and work within the organizational system. Mentors and coaches are invaluable resources for the new nurse manager as these new skills are acquired.

UNDERSTANDING ROLES
ROLES is a useful acronym to help remember the nursing roles of a nurse manager (Yoder-Wise, 2011). It stands for responsibilities, opportunities, lines of communication, expectations, and support.

Responsibilities address the answers to the following questions: What are the specific duties outlined in the job description? What types of clinical and management interventions are expected? Role functions for a nurse manager may include a 24/7 role in managing a single patient care unit or multiple units (Conway & McMillan, 2007), whereas a family nurse practitioner position description may include direct, hands-on care delivery in a walk-in clinic (Catalano, 2012). Every position in a healthcare agency has different responsibilities and role expectations contingent on the specific role held.

Opportunities are available, yet often unused, facets of a position. They may include the availability of tuition assistance that a nurse manager has not encouraged her staff to tap into for furthering their formal educations. Another example would be noticing the bulletin boards in the break room are empty; a nurse manager could see this as an opportunity to post educational materials or information relevant to a unique patient diagnosis on the unit. These examples provide opportunities for a nurse leader to present needed facts and creative changes to influence organizational and personal goals.

Lines of communication are often determined by roles within the organization. Nurse leaders must communicate issues that impact patient care. Effective communication is important to aid teamwork. Listening is one of the most difficult forms of communication. It is an active process that requires skill and practice (Shipley, 2010). Honed listening skills result in improved patient care outcomes.

Expectations vary according to individual goals. Staff nurses may be expected to work every other weekend. Nurses practicing in an operating room may be expected to take a turn on a call list rotation. Nurse managers are expected to have 24/7 accountability for their assigned areas of responsibility. Nurses should determine the written and unwritten expectations of a position, regardless of the specific job title, prior to accepting the position.

Support describes resources that are available to help job success. In some cases this includes experts who can be consulted to provide specialized knowledge. For example, a new critical care nurse can ask another staff nurse for an opinion related to a patient’s condition. A hospice nurse doing a home visit must have other resources to help guide decision making, because he or she practices independently. A nurse manager who does not have refined knowledge in legalities may want to know if he or she can consult with the hospital's attorney or director of risk management. Support systems must be available to facilitate smooth role transition. A common type of support system is a mentoring program.

Scope of Practice
A nurse manager must be fluent in the scopes of practice for the various clinical professions of his or her supervised employees, which may include nurse assistants, licensed practical nurses (LPNs), and registered nurses (RNs), among others. Maintaining easily accessible current resources that outline the various professional scopes of practice at the local, state, and national levels promotes patient safety (Huber, 2010). This knowledge base also ensures appropriate delegation of work assignments and builds confidence in the supervised employees.

Role of Evidence in Practice
Evidence-based practice has become the authority for making healthcare decisions and is essential to providing effective and safe patient care. For example, much has been written about new technologies such as electronic health records (EHRs). The EHR system can reduce healthcare costs, decrease error rates, increase quality care, and save lives. (See Box 14-1 for evidence associated with the benefits of using EHRs.)

The nurse manager must create a culture that promotes evidence-based practice to motivate peers to practice from this perspective. Practitioners should be expected to use the best and latest evidence to make decisions about patient care (Melnyk & Fineout-Overholt, 2005). Role modeling the use of scientific evidence in managerial decisions and promoting learning opportunities for staff can help create a culture of evidence-based practice.

Informatics
Nursing has progressed quickly from knowing how to use a computer at a work station, to developing methods and structures to code phenomena and designing technologies to support the practice of nursing (Makar, 2012). Electronic health records, clinical decision support systems, medication administration systems, inventory control programs, staff scheduling software, and databases are all examples of how informatics is part of the everyday health-care environment. Healthcare delivery relies on the collection, integration, coordination, and management of data to improve patient care outcomes, decrease costs, and report to regulatory agencies (Huber, 2010). Informatics competency and computer literacy are skills a nurse manager must possess to function in managerial and leadership roles. Safe patient care depends on the use of technology; the nurse manager is in a position to promote learning opportunities to peers to enable them to stay current in the use of emerging technology.

MENTORSHIP
Mentoring programs can ease the transition from student to professional nurse, acute care to critical care, and when moving between many other nursing positions held during a career.
**BOX 14-1: ELECTRONIC HEALTH RECORDS**

“Our recovery plan will invest in electronic health records and new technology that will reduce errors, bring down costs, ensure privacy and save lives.”

—President Obama, Address to Joint Session of Congress, February 2009

- EHRs improve care by enabling functions that paper records cannot deliver.
- EHRs can make a patient’s health information available when and where it is needed – it is not locked away in one office or another.
- EHRs can bring a patient’s total health information together in one place and always be current – clinicians need not worry about not knowing the drugs or treatments prescribed by another provider, so care is better coordinated.
- EHRs can support better follow-up information for patients – for example, after a clinical visit or hospital stay, instructions and information for the patient can be provided effortlessly; reminders for other follow-up care can be sent easily, or even automatically, to the patient.
- EHRs can improve patient and provider convenience – patients can have their prescriptions ordered and ready before they leave the provider’s office, and insurance claims can be filed immediately from the provider’s office.
- EHRs can link information with patient computers to point to additional resources – patients can be more informed and involved as EHRs are used to help identify additional web resources.
- EHRs don’t just “contain” or transmit information, they also compute with it – for example, a qualified EHR will not merely contain a record of a patient’s medications or allergies, it will also automatically check for problems whenever a new medication is prescribed and alert the clinician to potential conflicts.
- EHRs can improve safety through their capacity to bring all of a patient’s information together and automatically identify potential safety issues – providing “decision support” capability to assist clinicians.
- EHRs can deliver more information in more directions, while reducing “paperwork” time for providers – for example, EHRs can be programmed for easy or automatic delivery of information that needs to be shared with public health agencies or quality measurement, saving clinician time.
- EHRs can improve privacy and security – with proper training and effective policies, electronic records can be more secure than paper.
- EHRs can reduce costs through reduced paperwork, improved safety, reduced duplication of testing and, most of all, improved health through the delivery of more effective health care.


Mentoring programs are also successful in other types of industries. These programs are sometimes put in place to prepare people for management and executive level positions.

In one study, new graduate nursing mentorship programs reduced stress for the majority of graduate nurses who met with their mentors on a regular basis (Beecroft, Santner, Lacy, Kunzman, & Dorey, 2006). This same investigation cited that a lack of connection between the mentor and mentee was associated with schedule constraints and a lack of time and commitment.

Being involved cements the mentoring connection and solidifies the relationship between the mentor and mentee. When a mentee is unclear as to how to proceed or what to do next, he or she should ask the mentor. This gesture conveys respect for the working relationship. A successful mentoring bond is the responsibility of both parties.

Some basic traits of an ideal mentee are:
- hunger for knowledge
- willingness to “do what it takes”
- staying power
- risk taker
- positive attitude
- confidence
- good listener
- note taker
- critical thinker (asks well-thought-out questions)
- goal-directed
- takes initiative from feedback.

Another study by Burritt, Wallace, Steckel, and Hunter (2007) examined a clinical mentor model whereby senior, experienced nurses were not given direct patient care assignments and only supervised nursing care delivery. They found a significant reduction (47%) in the number of adverse events related to failure-to-rescue measures and patient falls decreased by 20%. It was estimated that $2,813,418 was saved financially as a result of decreasing 3192 excess days of care. Nurses reported improvements in all areas of nursing practice.

Mentors are experts in their chosen fields, which enables them to provide knowledge and guidance to fulfill mentees’ learning needs (Wensel, 2006). The relationship between a mentor and a mentee is a personal-choice, committed relationship, in which the expert and novice have a mutual interest. Mentors are typically highly experienced professionals. The knowledge they provide goes beyond formal educational programs and established curricula (Rose, Rukstalis, & Schuckit, 2005). They help their protégés learn values inherent in their discipline, provide direction, and instill self-confidence. Mentees are typically novice professionals who seek knowledge and guidance from experienced experts.

The mentor-mentee relationship is voluntary and typically lasts for many years. If you respect the work and admire the accomplishments of another nurse, ask if he or she would be willing to serve as a mentor. Formal mentoring programs may also be available through the workplace.

**PRECEPTOR PROGRAMS**

In nursing, a preceptor is an experienced nurse who teaches the skill, art, and science of nursing to nursing students, nurse interns, recent graduates of nursing programs, and new employees. The preceptor role in nursing encompasses more than teaching nursing skills; it includes role modeling, perceiving a situation as a whole, anticipating problems, applying nursing knowledge, and more. Unlike mentor-mentee relationships, preceptor programs are developed by healthcare facilities to educate nurses in teaching techniques, concepts of education, and standardized information provided to preceptors. Usually, a preceptor-preceptee relationship is an assigned one; rather than a voluntary one of personal choice.

Preceptor programs are often negotiated with schools of nursing. In such programs, student nurses pair with seasoned clinical nurses for a finite amount of time (usually 6 weeks) while they are in nursing school. A typical example of a preceptor program occurs in nursing leadership courses in the university setting. See Box 14-2 for a case study involving senior leadership student preceptor experiences in multiple clinical settings. The course professor matches student clinical interests and their geographic preferences and assigns them to a preceptor. Often, the clinical site is a hospital unit; however, other settings, such as hospice, long-term care, public health, and school nursing, also are used for student clinical placement. The nurse manager in each clinical setting may be involved in scheduling nurse-patient assignments for nurse preceptor programs. The nursing professor acknowledges the contributions of the nurse preceptors in the various clinical agencies.

Collaborative partnerships between nurses in academic institutions and those in clinical practice in several different healthcare agencies contribute to preparing the next generation of nurses. These working relationships are essential in light of the predicted shortages of bedside nurses when the baby boomer generation becomes older and needs more healthcare care. Changes in United States population demographics and increased longevity of our citizenry are expected to result in critical shortages of registered nurses in 30 states, especially in the Western United States (Jurashcek, Zhang, Ranganathan, & Lin, 2012). Significant RN shortages will be realized by 2030; therefore, it is imperative that nurses in all healthcare arenas collaborate in preceptor programs to provide the coaching necessary to practice in complex healthcare environments.

Although preceptor programs in schools of nursing are short in duration, role expectations of the faculty, student, and preceptor must work in harmony. Table 14-1 outlines major role expectations for all three parties. This relationship has positive features in that students gain knowledge and clinical skills and preceptors are able to participate in a
BOX 14-2: CASE STUDY – PRECEPTOR PROGRAMS

Dr. White is an associate professor of nursing at her university’s school of nursing who initiated a preceptor program for her senior-level leadership and management nursing students. She had 45 students in the class and contracted at 12 different healthcare agencies, several of which had multiple units involved.

During the 16-week semester, the students were divided into two different 8-week rotations for their preceptored leadership experience. The students completed a survey that requested their geographic and site or clinical specialty preferences. Dr. White secured permission from 23 different nurses with baccalaureate degrees in nursing to serve as clinical preceptors, several of whom have served as preceptors in the past and have many years of practice experience. At the end of the semester, the students reported that they had pragmatic and realistic clinical preceptor experiences and that their preceptors were excellent role models and teachers.

Discussion Questions
1. What should Dr. White do to acknowledge the clinical preceptors?
2. What services have the clinical preceptors provided to the profession?
3. What characteristics do the preceptors have that are beneficial for this teaching-learning experience?

See Box 14-3 for answers to these questions.

BOX 14-3: ANSWERS TO CASE STUDY – PRECEPTOR PROGRAMS

1. Dr. White should acknowledge the clinical preceptors in a very public way. They have provided a valuable service to the students and to the university; for example, the course professor can now take more assigned students because she has the assistance of several preceptors. Dr. White could petition the university to provide free use of the athletic center or access to the library for preceptors. A thank you letter should be sent to each preceptor, with a copy to the nurse managers and the chief nursing officers of the agencies. In addition, the school of nursing could host an end-of-year luncheon to acknowledge the preceptors. Each preceptor could be given a framed certificate and a small token of appreciation, such as a university mug or t-shirt. The preceptors’ services also could be acknowledged in the local newspaper and in agency newsletters.

2. The preceptors have taught future nurses (students) and modeled professional practice. Furthermore, they have modeled service to the profession to their peers (nurses in practice), who may in turn serve as future preceptors.

3. The preceptors have several characteristics that are beneficial to this educational experience:
   - nursing degrees
   - several years of nursing practice experience
   - previous preceptor experience
   - positive role modeling for students
   - positive role modeling to their staff nurse peers (future preceptors).

Critical Thinking Exercise

A nurse manager asks a nurse with 3½ years of experience on the intensive care unit to be a preceptor for a second semester junior nursing student. The staff nurse responds by saying that her patient load is usually moderate to high, and she is unsure if she can take on the added responsibility. She adds, “What would be a positive reason for me to become a preceptor?”

Answer: Becoming a preceptor has many benefits. The major reasons to do this are to help educate future nurses, gain student teaching experience, contribute to the profession, build organizational and leadership skills, and develop one’s professional portfolio or curriculum vitae (a complete list of one’s life work).

Nurse preceptor programs also benefit nursing students. Students learn to practice from experts and also learn the importance of giving to the profession by serving as a preceptor.

Graduate nursing programs can help ease the projected nursing shortage; however, while nurses are in graduate school, the patient care team may be stretched because most of these students work reduced hours (Williamson, Callaghan, Whittlesea, & Heath, 2011). These experienced nurses will graduate and provide new knowledge to their novice colleagues. Experienced nurses are not easily replaced, especially by new nurses who have little or no experience (Williamson et al., 2011). Providing support to nurses in master’s and doctoral programs during their formal education is important because they are the hospital’s future preceptors and mentors.

COACHING

In many cases, a nurse manager serves as a professional development coach to an individual or group within an organization (Yoder-Wise, 2011). The employees and manager interact on a frequent basis, with the major goal of optimum clinical performance. Coaching involves improving an employee’s abil-

TABLE 14-1: ROLE EXPECTATIONS OF STUDENT, PRECEPTOR, AND FACULTY

<table>
<thead>
<tr>
<th>Student</th>
<th>Preceptor</th>
<th>Faculty</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Attend assigned rotations</td>
<td>• Share work schedule with student</td>
<td>• Arrange clinical preceptor sites</td>
</tr>
<tr>
<td>• Review clinical objectives</td>
<td>• Orient student to clinical area, policies, procedures, and protocols</td>
<td>• Complete clinical skills checklist specific to clinical site</td>
</tr>
<tr>
<td>• Write personal objectives</td>
<td>• Review curriculum and course syllabus</td>
<td>• Provide students and preceptors with contact information</td>
</tr>
<tr>
<td>• Attend agency orientation</td>
<td>• Review student’s clinical and personal objectives</td>
<td>• Provide preceptors with course syllabi and relevant course materials</td>
</tr>
<tr>
<td>• Arrange schedule with preceptor</td>
<td>• Offer positive role-modeling</td>
<td>• Make clinical rounds</td>
</tr>
<tr>
<td>• Confer with preceptor regarding patient problems and treatment plans</td>
<td>• Direct students to written and personnel resources</td>
<td>• Be available to preceptors and students</td>
</tr>
<tr>
<td>• Submit required written work to faculty</td>
<td>• Provide interesting case mix</td>
<td>• Intervene with student issues</td>
</tr>
<tr>
<td>• Participate in clinic conferencing with faculty and other students</td>
<td>• Provide student with specific feedback</td>
<td>• Confer with preceptors on students’ progress</td>
</tr>
<tr>
<td>• Apply didactic course materials to clinical practice</td>
<td>• Provide evaluation data to course faculty</td>
<td>• Support and educate preceptors on educational needs and outcomes</td>
</tr>
<tr>
<td>• Keep a daily progress journal</td>
<td>• Collaborate with faculty regarding student progress</td>
<td>• Review students’ written work</td>
</tr>
<tr>
<td>• Practice within agency policies, procedures, and protocols</td>
<td>• Teach clinical skills to student and relate them to theory</td>
<td>• Provide recognition for preceptors</td>
</tr>
<tr>
<td>• Evaluate clinical experience, preceptor, and faculty</td>
<td></td>
<td>• Complete all evaluation tools for students with preceptor input</td>
</tr>
</tbody>
</table>
ity to perform his or her duties and increase potential (Huber, 2010). Coaching activities include role modeling, encouraging growth, creating a positive environment, and encouraging goal setting (Huber, 2010). A skilled nurse manager can foster cohesive team building when employees are effectively coached. Enhanced performance, exceptional communication, ongoing evaluation, and healthy working relations are the rewards for the manager and employee when coaching interventions are effective.

Coaching facilitates peer evaluation and constructive feedback for staff nurses (Yoder-Wise, 2011). Nurses must request to see performance appraisal tools so they are aware of expectations and objective information for which they are responsible (Chandra & Frank, 2004). Annual performance appraisals (evaluations) serve to motivate employees and enhance performance (Huber, 2010). Nurses gain clinical knowledge and learn leadership skills from nurse managers with excellent coaching skills.

**PROFESSIONAL PORTFOLIOS**

Nurses at all levels should assemble and maintain professional portfolios. The purpose of a professional portfolio is to showcase your work. Portfolios have many purposes. Nurses can take a well-organized portfolio with them on job interviews. When a prospective employee presents a portfolio, it makes a great first impression. Another reason for keeping a portfolio is to have a systematic way to keep track of continuing education (CE) hours or units. Many state boards of nursing require documented evidence of CE attainment for license renewal. The hours of CE that are required vary by state. In mandatory CE states, nurses are randomly selected to present evidence for CE hours. Therefore, it is important for the nurse to establish a pattern for keeping records of CE hours and other professional information. The initial work in assembling the portfolio can be time consuming; however, keeping it current will become a routine part of the professional nurse’s role (Catalano, 2012).

Online portfolio systems are an option that nurses may choose to represent their professional abilities. The online portfolio is an extension of the curriculum vitae that shares the individual’s significant accomplishments, licenses, certificates, and other important documents and information as well as formal university degrees. The online portfolio is on the Internet; therefore, it travels with the nurse. If an opportunity presents itself, the nurse can access the online portfolio and be ready to share information for a new position. Nurses can access information online about professional portfolios because the cost varies among companies that provide these services.

**Organizing the Portfolio**

Organizing a portfolio in a three-ring binder is recommended (Catalano, 2012). The front cover should have the nurse’s name, followed by his or her credentials. For example, a nurse would write, Jane Smith, MSN, RN, ONC. This tells the reader at first glance about the nurse’s graduate education level and area of expertise (in this case, orthopedic nursing; the ONC credential indicates Orthopaedic Nurse Certified, which is granted by the National Association of Orthopaedic Nurses).

**Sections within the Portfolio**

The first page within the binder should be the table of contents. The nurse must think about specific sections that he or she would like to include in the portfolio because they are unique to each nurse. For example, an LPN who is seeking a charge nurse position in a long-term care (LTC) facility will want to showcase his or her various clinical positions in other LTC facilities and nursing home settings, positive annual performance evaluations, CE certificates (especially in the gerontology specialty), and other highlights that have occurred within the nurse’s career.

The nurse should be sure to include a section for educational information. Nurses holding degrees should indicate the specific field. See Box 14-4 for education-related information to include in the professional portfolio.

Specific sections within the portfolio can be a platform for attainment of a desired position. An “Acknowledgements” section may include letters from grateful patients, members of the community, or nursing students; however, if this section is included, the nurse should ensure that it is completed tastefully.

Samples of completed work also can be displayed within the portfolio. A staff nurse on a general medical-surgical unit may choose to share a patient teaching brochure on the subject of nutrition that he or she developed for patients with diabetes. See Box 14-5 for examples of information a nurse can collect to place in the professional portfolio.

**Categories**

Each nurse should organize the portfolio in the basic categories that reflect his or her major professional roles and showcase his or her work. This is the nurse’s opportunity to highlight educational background, professional certifications, work experience,
specialized skills, and major achievements. The nurse should take the opportunity to display the uniqueness of his or her professional role. See Box 14-6 for a possible way to organize the professional portfolio.

**Polishing the Portfolio**

When the portfolio is assembled, share it with a mentor or another experienced nurse for editorial comments and critique. Edit the portfolio to give it a clear, crisp, and professional look. Invest in buying page protectors to enhance the professional look of the portfolio and protect the work. A well-done portfolio can make a candidate stand out over others who may be vying for the same position within an organization.

**GROOMING SUCCESSIVE LEADERS**

Leadership and management skills can be learned. Commonly, novice nurses turn to preceptors and mentors to develop and hone their clinical and management skills. Use of case studies, Web sites, and interactive activities builds leadership competencies (Williamson et al., 2011).

Seminal research done by Allen (1998) supports that five dominant factors enhance leadership development: self-confidence, innate leadership qualities, progressive successful experiences, influential mentors, and personal life factors. Interestingly, most of the respondents in Allen’s research were involved in sports as team captains and as officers in student government associations. Many chose to further their formal education in nursing administration, a form of progressive experience and success. The respondents reported positive experiences with mentors that facilitated their heightened self-confidence.

Nurses are responsible for their successors. By serving as formal educators, coaches, preceptors, and mentors, experienced nurses can share clinical expertise, model professional behaviors, teach leadership principles, and groom successive nurse leaders in the discipline.

**SUMMARY**

Over the course of a career, a nurse will serve in many different roles. The span of one’s career can range from student to novice, mentee to competent practitioner, and then to role model, coach and, eventually, to mentor. Nurses make several professional role transitions across the span of their careers. Experienced nurses must serve as positive role models to new nurses. They must demonstrate leadership skills and serve as coaches, preceptors, or mentors to ensure establishment of future leaders in the nursing profession.

**Answer the self-assessment questions for Chapter 14 at the end of the course.**

**RESOURCES**

American Leadership Forum  
http://www.alfnational.org

The Institute for Collaborative Leadership  
http://www.collaborative-leaders.org

The Office of the National Coordinator for Health Information Technology  
http://healthit.hhs.gov/portal/server.pt/community/healthit_hhs_gov__home/1204

---

**BOX 14-5: PROFESSIONAL PORTFOLIO COLLECTIONS**

- Samples of annual performance evaluations
- Examples of leadership skills
- Clinical skills, which includes equipment use knowledge
- Examples of using evidence-based data put into practice
- Samples of scholarly works

When including examples in the portfolio, use the original documents if available. When making copies, obtain a print and color copy. Examples of documents the nurse could place in the portfolio to support the above areas are:

- Employee of the month or year awards
- Letters of commendation
- Letters from consumers (students, patients, public)
- Positive notes or memos from other professionals, including administrators
- Patient teaching brochures
- Published journal articles
- Platform presentation acceptance letter(s)
- Professional memberships – include roles (i.e., committee memberships, chairperson role(s), elected board membership, elected officer)
- Grant awards
- Sample PowerPoint presentations
- Nursing handbook(s)
- Program of research or scholarship
- Professional certifications (indicate specialty)
- Continuing education activities
- Staff development presentations
- Reference letters
- Poster presentation picture(s)
- Case studies
- Clinical simulation modules
- Marketing plans
- Research and program proposals (for funding)
- Lecture notes
- Scholarships

---

**BOX 14-6: PROFESSIONAL PORTFOLIO CATEGORIES**

- Career goal: What role do you aspire to have in 5 years? 10 years?
- Professional philosophy and values: What guides your professional role and nurse practice?
- Teaching philosophy: What teaching-learning strategies best reflect effective education?
- List of professional memberships: List organizational memberships and your role within the organization.
- Continuing education (CE), staff development sessions attended: Include copies of all CE/staff development sessions attended.
- Publications: List all publications and cite whether they are published in refereed journals or are monographs.
- Presentations: List all platform presentations and break down whether the levels were local, state, regional, national, or international; cite if the presentation was accepted through a juried process.
- Grants: Individually list all grant proposals that were funded; also list those that were unfunded, to support the efforts made.
- Formal education: List all degree programs and specialty focuses.
- Certifications: List basic cardiac life support (BLS), advanced cardiac life support (ACLS), pediatric life support (PALS); clinical and professional certifications through professional organizations; advanced practice nursing certifications.
- Letters of recommendation: Include letters from instructors for nursing school, patients, professional peers, and employers.
- Awards and honors: List all awards and honors received; examples include the Million Dollar Club for grant acquisition, service recognition awards, and employee of the month.
- Community and public service: List any volunteer activities in the community (i.e., spearheaded a community health fair or minority health fair).
- Courses Taught: List courses taught to showcase breadth of knowledge.
- Resume or curriculum vitae (CV): Concisely list all of your accomplishments. This can be placed directly after the table of contents, and categories within the portfolio can reflect the categories on the resumé or CV.
CHAPTER 15: LEADING THROUGH INVOLVEMENT IN PROFESSIONAL ORGANIZATIONS

CHAPTER OBJECTIVE

After completing this chapter, the learner will be able to explain how professional organizations provide leadership opportunities.

LEARNING OBJECTIVES

After reading this chapter, the learner will be able to:

1. Define professional nursing organizations.
2. Describe the personal and professional benefits of membership in professional organizations.
3. Outline the benefits of professional networking.
4. Recognize skills that can be learned through active involvement in professional organizations.

CHAPTER OBJECTIVE

Present-day nursing is a complex discipline that is shaped by knowledge, economics, society, and the specific demographics of a region, including population and culture (Hader, 2006). Career commitment is the nurse’s outlook toward nursing as a distinct profession and the nurse’s motivation to practice in his or her chosen career.

Nursing is a profession that includes a variety of role functions, such as hands-on practitioner, educator, researcher, leader, manager, service provider, and more. Nursing professionals have a contract with the public to provide services for the public good (Hader, 2006). Oftentimes, nurses practice in specialty fields, have special interests, and a desire to network with other nursing professionals. To accomplish professional networking, many nurses belong to nursing organizations.

PROFESSIONAL ORGANIZATIONS

A professional nursing organization or association is a coalition of nurses that provides networking opportunities for nurses in the field to participate in health policy formulation, obtain continuing education, develop or sharpen leadership skills, and shape the profession (Yoder-Wise, 2011). The various professional nursing organizations each focus on different interests. For example, if a nurse is involved in research and wants to learn more about current findings to promote evidence-based practice, he or she could affiliate with a local or regional nursing research society such as the Southern Nursing Research Society or national organizations such as Sigma Theta Tau International (the Honor Society of Nursing).

Nurse educators may want to belong to the National League for Nursing (NLN), National Organization for Associate Degree Nursing, or the Association for Nursing Professional Development. There are also numerous clinical practice specialty organizations and professional organizations dedicated to different clinical, cultural, and professional groups of nurses and other healthcare professionals.

Table 15-1 provides an extensive listing of professional nursing organizations. Most of these organizations have Web sites that explain their mission, vision, philosophies, and goals. Web sites are one way of learning about an organization and its key players, committee structure, and strategic plans, prior to making a commitment to join.

BENEFITS OF BELONGING TO PROFESSIONAL ORGANIZATIONS

Several different motivating factors influence a nurse’s decision to join a professional organization. Membership is an important component of career development. Nurses may belong to several organizations, depending on their professional and social interests. Being involved in professional organizations and associations has many benefits (see Table 15-2).

Reasons to Belong to Professional Nursing Organizations

Nurses join professional organizations for many different reasons. Membership can be an integral component in promoting a nurse’s career. For example, serving as chairperson of a prestigious committee can increase the nurse’s awareness of potential funding opportunities for scholarship-based grants. Sharing this information with nurses in the field increases individual networking and position power. Often, when a nurse is a member of a program or conference planning committee, his or her time is compensated by having registration to the association’s annual convention paid for along with hotel travel reimbursement by the organization. Nurses with graduate degrees are often sought after to belong to committees because they bring knowledgeable participants to the association and added prestige for the organization. Nurses who are in community college and university teaching positions are required to report their work within the triad of expectations, which involves teaching, service, and research (scholarship). Active membership in a professional organization is one way to demonstrate service to the profession.

Nurses commonly are busy at different points in their careers with such obligations as raising a family, being a caregiver for a parent, returning to school for advanced degrees, or myriad other reasons and cannot be active on committees or run for elected offices. As a dues-paying member, the nurse is involved in a professional organization and the support, through the dues, is an investment in one’s career. Membership travel reimbursements at the local (district), state, national, and international levels. Communicating time constraints, professional interests, and goals for belonging are helpful in clarifying the degree of involvement in the organization. Being proactive prevents potential frustration and promotes a positive experience.

Personal Benefits

Many substantial personal benefits are associated with involvement in a professional organization. Networking with nurses at varying levels of their careers can provide a view of different career opportunities in the same specialty field. For example, a novice orthopedic nurse may aspire to continue formal education and become an advanced practice nurse practitioner who focuses on musculoskeletal disorders. The nurse may find it useful to accept a leadership position on the nursing association’s education committee where, through networking, he or she could receive information about programs and opportunities in graduate nursing education. Undoubtedly, the nurse would also gain experience in building effective teams and would learn conflict resolution and problem-solving strategies. (See Table 15-3.) Leadership involvement facilitates networking and collaborating with organizational leaders. Building confidence in a leadership role prepares nurses to apply for assistant nurse manager positions which, in turn, may prompt them to go on for advanced degrees in nursing administration. Mentors in professional organizations provide expertise and experiences that are invaluable to lesser-experienced nurses. They can recommend graduate schools that have excellent curricula, faculty, resources, and reputations for graduates who are sought after for employment.

Another personal benefit is specialty certification. Certification acknowledges advanced knowledge in a nursing specialty that is beyond the knowledge required for initial nursing licensure. Each organization has its own criteria to sit for its certification exam, and nurses must research these requirements. Professional nursing certification lends expert credibility to the nursing professional. Another benefit of certification is that it is often a recommendation, and sometimes a requirement, for clinical track nurse faculty in associate degree and baccalaureate nursing programs. Additionally, some hospitals and healthcare organizations provide a differential or stipend for certification in a nursing specialty.

Another personal benefit of membership in professional organizations is the acquisition of presentation skills. Professional organizations publish a call for abstracts prior to annual conferences. Nurses in practice may be reluctant to speak in front of groups, and a great way to gain presentation skills is to present a poster. A poster is a graphic representation of a topic. It is much less intimidating for those new to presentation to stand by their posters and have one-on-one conversations on a topic that is interesting to them. In many cases, nurses gain confidence from these poster presentations and go on to submit platform (paper presentation) abstracts. Nurses new to orally presenting papers may choose to co-present or be a member of symposium presentations, in which there are usually three or more speakers. (See Box 15-1 for an example of how involvement in organizations can foster personal growth and boost one’s nursing career.)

Understanding the most current innovations in clinical practice is another substantial benefit of belonging to professional nursing organizations. Many organizations affect health policy by publishing position statements on various issues and actively advocating for those positions when appropriate. For example, the National Association of Orthopaedic Nurses published a position statement on seatbelt use, as did many other nursing organizations. Using the position papers as a point of reference, nurses advocated for implementation of legislation in their states. Later, it became law in most states that persons must wear seat belts while driving. Joining an organization’s legislative committee can put nurses in touch with the political players in their voting districts. If a nurse is interested in a future political career, involvement in a professional organization can be an excellent...
activity to lead to that aspiration. Many nurses have held political offices at local, state, and national levels. Influencing policymakers and effecting positive change is an important personal member benefit.

**Professional Benefits**

Membership in a professional organization can launch a career in directions not able to be navigated individually. Positions in other institutions or opportunities within the organization itself are availed to people who belong. In addition, the public recognizes nurses who become certified in specialty fields for their competence and focus on quality of care (Hader, 2006).

Another professional benefit is gaining allies who are leaders in the field. These leaders may serve as references for other career opportunities or leadership positions within the organization. Nurses working in Magnet recognized organizations are commonly certified. In Magnet organizations education and credentials are highly valued. Like a magnet, Magnet organizations attract the very best qualities from their professional employees. Advancing nursing’s agenda with a unified voice is very powerful!

**NETWORKING**

Professional organization meetings offer nurses opportunities to collaborate and establish personal as well as professional networks. Networking is a two-way street – both parties need to exchange information to help achieve their goals (Finkelman, 2012). Sharing information is an effective way to set a positive tone in a relationship.

People establish networks through work associations, continuing education (formal or informal), professional associations and meetings, church affiliations, and personal-life situations (Finkelman, 2012). Sometimes, people met in one’s personal life are tapped years later in one’s professional career. Nurses in the academic and service sectors are learning the importance of establishing connections because of the shortage of bedside nurses and the more severe shortage of nurses in univer-

### TABLE 15-1: LIST OF PROFESSIONAL NURSING ORGANIZATIONS

<table>
<thead>
<tr>
<th>Organization</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Academy of Medical-Surgical Nurses (AMSN)</td>
<td>Association of Rehabilitation Nurses</td>
</tr>
<tr>
<td>Academy of Neonatal Nursing</td>
<td>Association of Women’s Health, Obstetric &amp; Neonatal Nurses (AWHONN)</td>
</tr>
<tr>
<td>Alliance for Psychosocial Nursing (APN)</td>
<td>Canadian Nurses Association</td>
</tr>
<tr>
<td>American Academy of Ambulatory Care Nursing</td>
<td>Eastern Nursing Research Society (ENRS)</td>
</tr>
<tr>
<td>American Academy of Nurse Practitioners</td>
<td>Emergency Nurses Association (ENA)</td>
</tr>
<tr>
<td>American Assembly of Neuroscience Nurses (AANN)</td>
<td>Home Healthcare Nurses Association</td>
</tr>
<tr>
<td>American Assisted Living Nurses Association</td>
<td>Hospice &amp; Palliative Nurses Association</td>
</tr>
<tr>
<td>American Association for the History of Nursing</td>
<td>International Association for Human Caring</td>
</tr>
<tr>
<td>American Association of Colleges of Nursing (AACN)</td>
<td>International Society of Nurses in Genetics</td>
</tr>
<tr>
<td>American Association of Critical-Care Nurses (AACN)</td>
<td>International Society of Psychiatric Mental Health</td>
</tr>
<tr>
<td>American Association of Heart Failure Nurses</td>
<td>Infusion Nurses Society (INS)</td>
</tr>
<tr>
<td>American Association of Legal Nurse Consultants</td>
<td>Midwest Nursing Research Society</td>
</tr>
<tr>
<td>American Association of Managed Care Nurses</td>
<td>National Association of Neonatal Nurses</td>
</tr>
<tr>
<td>American Association of Neuroscience Nurses</td>
<td>National Association of Nurse Massage Therapists</td>
</tr>
<tr>
<td>American Association of Nurse Anesthetists</td>
<td>National Association of Orthopedic Nurses</td>
</tr>
<tr>
<td>American Association of Nurse Attorneys</td>
<td>National Association of Pediatric Nurse Associates and Practitioners</td>
</tr>
<tr>
<td>American Association of Occupational Health Nurses</td>
<td>National Association of School Nurses</td>
</tr>
<tr>
<td>American College Health Association</td>
<td>National Black Nurses Association</td>
</tr>
<tr>
<td>American College of Nurse Practitioners</td>
<td>National Gerontological Nursing Association</td>
</tr>
<tr>
<td>American College of Nurse-Midwives (ACNM)</td>
<td>National League for Nursing (NLN)</td>
</tr>
<tr>
<td>American Forensic Nurses</td>
<td>National Nurses Society on Addictions</td>
</tr>
<tr>
<td>American Holistic Nurses’ Association</td>
<td>National Organization for Associate Degree Nursing</td>
</tr>
<tr>
<td>American Medical Informatics Association</td>
<td>Navy Nurse Corps Association</td>
</tr>
<tr>
<td>American Nephrology Nurses Association</td>
<td>Neonatal Nurses Association</td>
</tr>
<tr>
<td>American Nurses Association (ANA)</td>
<td>Nursing Network on Violence Against Women International</td>
</tr>
<tr>
<td>American Nursing Informatics Association</td>
<td>Oncology Nursing Society</td>
</tr>
<tr>
<td>American Organization of Nurse Executives (AONE)</td>
<td>Pediatric Endocrinology Nursing Society (PENS)</td>
</tr>
<tr>
<td>American Psychiatric Nurses Association</td>
<td>Sigma Theta Tau International, Honor Society of Nursing (STT)</td>
</tr>
<tr>
<td>American Radiological Nurses Association</td>
<td>Society for Vascular Nursing</td>
</tr>
<tr>
<td>American Society for Pain Management Nurses</td>
<td>Society of Gastroenterology Nurses and Associates</td>
</tr>
<tr>
<td>American Society of PeriAnesthesia Nurses (ASPN)</td>
<td>Society of Otorhinolaryngology and Head-Neck Nurses</td>
</tr>
<tr>
<td>American Society of Plastic Surgical Nurses</td>
<td>Society of Pediatric Nurses</td>
</tr>
<tr>
<td>American Thoracic Society, Nurses Section</td>
<td>Society of Urologic Nurses and Associates</td>
</tr>
<tr>
<td>Association for Nursing Professional Development</td>
<td>Southern Nursing Research Society</td>
</tr>
<tr>
<td>Association for Radiologic &amp; Imaging Nursing</td>
<td>Space Nursing Society</td>
</tr>
<tr>
<td>Association of Child Neurology Nurses</td>
<td>Transcultural Nursing Society</td>
</tr>
<tr>
<td>Association of Camp Nurses</td>
<td>Uniformed Nurse Practitioner Association</td>
</tr>
<tr>
<td>Association of Child and Adolescent Psychiatric Nurses</td>
<td>Visiting Nurse Association of America</td>
</tr>
<tr>
<td>Association of Nurses in AIDS Care</td>
<td>Wound, Ostomy and Continence Nurses Society (WOCN)</td>
</tr>
<tr>
<td>Association of Pediatric Oncology Nurses</td>
<td>Several state nursing organizations can be accessed at <a href="http://www.nurse.org/orgs.shtml">http://www.nurse.org/orgs.shtml</a></td>
</tr>
</tbody>
</table>

*Note: The table lists various professional nursing organizations. The full list can be accessed at the provided URL.*
TABLE 15-2: BENEFITS OF BELONGING TO PROFESSIONAL NURSING ORGANIZATIONS

- Certification related to that organization is usually offered at a discounted rate
- Access to discipline-specific (specialty) standards of practice
- Political advocacy
- Access to staff experts
- Networking opportunities with leaders in the field
- Newsletters with helpful information
- Position statements to educate and protect the public
- Continuing education offerings
- Professional journal (published by the organization)

Anecdotal Note: Active membership in professional nursing and health organizations are an expectation for the service component of the “triad of expectations” for nurses in a university setting.

TABLE 15-3: OPPORTUNITIES FOR SKILLS ACQUISITION FOR ACTIVE PARTICIPANTS IN PROFESSIONAL ORGANIZATIONS

- Confidence building in leadership role
- Leadership
- Delegation
- Conflict resolution
- Finding voice – professional presentation
- Health policy development
- Team building
- Consensus building
- Political activism
- Networking
- Fund raising
- Speaking in front of small groups
- Directing meetings
- Creating agendas
- Strategic thinking
- Strategic planning
- Time management

BOX 15-1: CASE STUDY – PROFESSIONAL NURSE

Kelly is a staff nurse on the intermediate care unit (IMCU) at a large, teaching, research regional referral center in Detroit. She has been an RN for 4 years and holds a Bachelor of Science in Nursing degree from the University of Michigan. She is a member of the American Association of Critical-Care Nurses (AACN) and is the chairperson of the continuing education committee for her local chapter. Kelly is interested in serving the organization at the national level. She is on the Professional Standards Committee at her hospital and her membership in the AACN gives her access to their professional standards of practice for critical care nursing. She is employed full-time on the IMCU and is the charge nurse two assigned weekends per month. She is a member of the Michigan Nurses Association (MNA) and receives Michigan nursing specialty organizations should be contacted to determine the requirements for becoming certified. Many hospitals require that a nurse hold the baccalaureate degree to be eligible to apply for middle management positions (assistant nurse manager or nurse manager). If this is not a requirement and there are multiple applicants, the person holding the university baccalaureate or higher degree has a distinct advantage over other applicants in the pool. Furthermore, hospital organizations making application for Magnet status prefer the baccalaureate-prepared RN in order to achieve the 80% minimum required baccalaureate-prepared nurses in their workforce that makes their application competitive.

Likewise, in a university setting, a requirement for tenure is to hold a doctoral degree in nursing or a related field. Other job classifications are developed, such as lecturer, clinical-track, and clinical teaching faculty, for nurses who hold Master of Science in Nursing degrees. Advanced degrees can advance a nurse’s career.

Nurse Certification

Nurse certification recognizes advanced knowledge in an area of nursing practice (Cherry & Jacob, 2008). Nurse licensure is distinctly different from certification. Registered nurse licensure reflects that the nurse met a minimum standard for nurse practice.

Some university settings offer additional education in certain fields, such as informatics, management, and critical care. Programs vary in duration and lead to the awarding of a certificate. Nurses are therefore recognized as having advanced knowledge and skill; however, certificate programs often lack the credit hours and coursework needed to complete a master’s program of study.

Specially organizations in nursing provide courses that lead to certification in the different fields of nursing. Advanced practice nurses (APN) must take and pass a certification examination in their chosen field of advanced practice before they can independently see patients. The first advanced practice specialty field to certify nurses was anesthesia in 1946 (Cherry & Jacob, 2008). Later, in 1961, the American College of Nurse Midwives had their own certification process for nurse midwives. At that time, several other specialties recognized the need to standardize different nursing programs. Therefore, in 1975, the American Nurses Association convened a group of nursing professionals in which 75 different specialty organizations were represented. This group recommended that a central body be developed, which became the American Nurses Credentialing Center (ANCC). Today, the ANCC certifies nurses in several different specialty fields, clinical nurse specialists, and advanced practice nurses. See Box 15-3 to view the specialty certification fields.

Nurses should research the requirements for certification in their fields of interest. The ANCC or nursing specialty organizations should be contacted to determine the requirements for becoming certified. Maintaining a minimum number of practice hours is required in many of the fields, especially in advanced practice nursing roles.
time to pursue specialty certification. However, nurses should use an organized file system to submit their CE portfolio; nurses randomly to submit their CE portfolio; several boards of nursing select online to determine the exact requirements for license renewal. Several boards of nursing select nurses randomly to submit their CE portfolio; therefore, nurses should use an organized file system to maintain their certificates of completion for successfully completed CE courses.

**Continuing Education**

Many nurses are unable to participate in formal degree-granting programs or take the time to pursue specialty certification. However, all nurses must remain current in their respective fields of nursing practice. Many healthcare organizations offer staff development programs to provide additional information about new treatment modalities or leadership and management programs. These programs are beneficial to professional nurses practicing in certain specialty units. Charge nurses benefit from attending staff development sessions in personnel-related issues, such as effective communication, managing conflict, enhancing quality outcomes, and many other related topics.

Some states require formal continuing educational (CE) hours for nurse license renewal. Nurses can visit their respective state board of nursing online to determine the exact requirements for license renewal. Several boards of nursing select nurses randomly to submit their CE portfolio; therefore, nurses should use an organized file system to maintain their certificates of completion for successfully completed CE courses.

**SUMMARY**

Every nurse should be involved in the nursing profession. Professional organization involvement can take many shapes, from being a dues-paying member to being an advanced practice nurse making policy recommendations that can influence patient care outcomes. This chapter outlined the personal and professional benefits of involvement in nursing organizations and the importance of networking. It also offered information regarding the importance of nurses being active participants in their own professional development.

**Answer the self-assessment questions for Chapter 15 at the end of the course.**

**RESOURCES**

American Nurses Credentialing Center (ANCC)  
http://www.nursecredentialing.org


Florida Center for Nursing, Internet Resources  
http://www.flcenterfornursing.org/  
InternetResources.aspx

International Council of Nurses (ICN)  
http://www.icn.ch

National Council of State Boards of Nursing  
https://www.ncsbn.org/index.htm

Nursing Organization Links  
http://www.nurse.org/orgs.shtml

**CONCLUSION**

The learner was exposed to several leadership and management concepts within this book. Nurses have different leadership and management styles, and knowing the different ways of leading helps staff nurses in their roles as patient advocates and caregivers. Learning how to delegate appropriately and the decision making involved in making assignments assist the nurse in making sound determinations. The effective nurse manager knows how to deal with conflict and dissent in the workplace.

Nurses must know how to use resources appropriately and be key players in the strategic planning process. Nurses must be at the table when important decisions are being made, from issues affecting patient care protocols to constructing a new physical plant.

Being proactive members of the healthcare team and involvement in the profession through professional nursing roles and active membership in state, national, and international organizations are important roles for nurses. The professional nurse must understand ethical principles and know the resources available to effectively handle complex ethical situations that involve the patient, the family, the nurse, and other members of the healthcare team. Managing ethical dilemmas through the use of resources within the organization helps the nurse to effectively deal with stressors in daily practice.
We live in a fast-paced high-tech environment; therefore, nurses must be knowledgeable about legal principles that affect nursing practice. Electronic health records and other technologies involving the patient and patient record must be viewed by those providing care to the patient. Patient privacy must be protected. By working through the modules, the learner gained knowledge regarding maintaining confidentiality and practicing within legal guidelines outlined in the individual state nurse practice acts.

Upon completion of this course the learner has gained knowledge of basic leadership and management concepts. The chapter exams, case study scenarios, and additional resources within each chapter prepared the learner to take the 100-question exam for the entire course.

To see a full list of references for the course, go to www.ce-express.com

**Glossary**

- **accountability**: Liability for action taken.
- **acknowledgment**: Recognition that an employee is valued and respected for what he or she has to offer to the workplace, team, or group; acknowledgments may be verbal or written, public or private.
- **active listening**: Focusing completely on the speaker and listening without judgment to the essence of the conversation; an active listener should be able to repeat accurately at least 95% of the speaker’s intended meaning.
- **affirmative action**: Policies that protect individuals based upon their race, religion, color, gender, or national origin.
- **American Nurses Association (ANA)**: A full-service professional nursing organization representing all registered nurses in the United States.
- **American Nurses Credentialing Center (ANCC)**: National nursing organization that administers nearly 40 specialty and advanced practice certification examinations each year (the only national system for accreditation and approval of continuing nursing education).
- **ANA Code of Ethics**: Set of ethical guidelines with nine interpretative statements that inform nurses’ ethical decision making.
- **assistant personnel**: Unlicensed caregivers.
- **authority**: The right to give directives and orders to another person.
- **autocratic leadership**: Leadership style that uses power and control to direct the workforce.
- **autonomy**: An individual’s right to determine what happens to one’s person.
- **beneficence**: Actions taken that promote good.
- **bioethics**: Ethics applied in the health-related professions.
- **biomedical model of medicine**: Medicine that is provided by a medical doctor or an osteopathic doctor and allied health professionals, such as nurses, physical therapists, and psychologists. Also referred to as conventional, western, or allopathic medicine.
- **block staffing**: Scheduling a fixed staff mix for each shift.
- **board of nursing**: Agency authorized to develop, implement, and enforce administrative rules and guidelines and other responsibilities per the state nurse practice act.
- **breach**: Falling below the established standard of care.
- **bullying**: An imbalance of power that results in an intention to harm with repeated occurrences.
- **capital expenditure budget**: Costs related to major expenses, such as equipment and the physical plant.
- **career commitment**: Outlook toward nursing as a distinct profession and a nurse’s motivation to practice in his or her chosen career.
- **causation**: A direct link between a nurse’s action or inaction and patient harm.
- **centralized scheduling**: Assigned work shifts scheduled by a scheduling coordinator.
- **centralized structure**: Hierarchical structure arranged by specialty areas (depicted as tall structure).
- **certification**: Expert knowledge in a nursing specialty field beyond registered nursing licensure.
- **charismatic power**: Personal power that inspires followership.
- **child abuse**: Maltreatment that involves physical assault, psychological neglect, sexual abuse, or emotional (including verbal) abuse.
- **child neglect**: Persistent inability to meet a child’s basic needs (food, clothing, shelter, supervision).
- **civil law (common law)**: Law that regulates actions of individuals and corporations in a society; a nurse practice act is a form of civil law.
- **coach**: Person who works with an individual or a group for professional development.
- **coercive power**: Power based on penalties or punishments that might be imposed.
- **commitment**: A state of being emotionally impelled; feeling passionate about and dedicated to a project or event.
- **comparing fault**: Charges that the patient contributed to his or her own injury.
- **complementary and alternative practices of healthcare**: The practice of using an alternative medical approach in addition to usual conventional healthcare or in place of conventional healthcare. Also referred to as complementary and alternative medicine (CAM).
- **confidentiality**: Patient’s right to privacy of his or her medical record.
- **connection power**: Power based on links to influential people.
- **consensus**: Valuing the divergent opinions of group members and reaching a final conclusion supported by the whole.
- **consortium**: The legal right to sexual services provided by one’s spouse.
- **contractual allowance**: Discount from full charges.
- **creativity**: Production of as many ideas as possible to efficiently resolve issues and solve problems.
- **critical thinking**: A complex cognitive process that is a combination of the nurse’s use of knowledge, attitudes, and skill.
- **curriculum vitae**: An exhaustive list of one’s life work.
- **damages**: Monetary award for a malpractice event.
- **decentralized scheduling**: Setup in which a nurse manager or unit nurses complete the work schedule for a hospital unit.
- **decentralized structure**: Hierarchical structure without many different decision-making layers (graphically depicted as flat).
- **decision grid (or matrix)**: Tool that allows a decision maker to compare several items based on the same criteria.
- **decision making**: A focused and goal-directed attempt to use a logical process to choose from different options.
- **decision tree**: Schematic representation that helps organize key elements in a situation by placing all possible events on the tree and having the decision makers refine events until a decision point is reached.
- **defendant**: Party being sued (may be a physician, nurse, therapist, or hospital).
- **delegate**: Person to whom a delegated activity is directed.
- **delegation**: Transferring to a competent individual the authority to perform a selected nursing task in a selected situation.
- **delegation decision making**: Assignment decision based on the required patient tasks, patient problems, and capabilities of the nurse in a given situation.
- **delegator**: Person who delegates an activity.
- **democratic leadership**: Leadership style in which leaders are more participatory and share authority with other healthcare team members.
- **denial of allegations**: Defense in which an attorney argues that a nurse did not do what was alleged in the complaint.
- **dialect**: A regional form of speech.
- **direct care**: The hands-on care given to a patient.
- **direct expense**: Cost directly associated with patient care, such as consumable supplies and medications.
- **disclosure of information**: Amount of information provider shares to ensure patient comprehends medical information.
- **domestic violence**: Any act of physical, emotional (psychological), or sexual abuse that occurs to any person.
- **dualism**: An “either/or” way of conceptualizing reality in terms of two opposing sides or parts (right or wrong, yes or no), limiting the broad spectrum of possibilities that exists between.
- **duty**: Minimum standard of care required for satisfactory nursing practice.
- **dysfunctional group**: Group behaviors that interfere with attaining quality outcomes for staff, healthcare professionals, and patients.
- **educational degree**: Diploma conferred by a college or university that signifies successful completion of a program of study.
- **effective communication**: A process that leads to positive outcomes for senders and receivers in terms of clarity, usefulness, and efficiency.
- **elder abuse**: Physical neglect or abuse, psychological or emotional abuse, financial abuse, or sexual abuse against an elderly person.
- **elder neglect**: Occurs when a vulnerable elder cannot complete self-care activities and goes without a bath, food, warm clothing, or appropriate shelter.
emancipated minor: A person who is younger than the age of majority as determined by state law but has the legal authority to make his or her own decisions.

empowered environment: Environment that encourages nurses’ active involvement in decision making and initiating actions that promote positive outcomes.

error of commission: Error that occurs when a nurse or other healthcare provider fabricates information and documents it in the medical record.

error of omission: Error that occurs when a nurse fails to make a notation in the medical record.

ethical dilemma: Conflict between two or more ethical principles for which there is no right or wrong decision.

ethics: A declaration of what is right, what is wrong, and what ought to be.

ethics committee: Group of individuals that provide long- and short-term assistance, education, policy development, case review, and consultation services to healthcare professionals.

event form: Surveillance system that classifies data and determines trends in serious adverse events in healthcare facilities.

expert power: The ability to influence others.

expert witness: Witness who gives testimony in a court of law to determine applicable and acceptable standards of practice based on a specific case to assist the judge and jury in understanding the standards of care.

facilitate autonomy: Offering choices for treatment.

factor system: An objective patient classification system that quantifies a care indicator with a weight or number.

fidelity: Keeping one’s word, promise, or agreements made.

fishbone diagram: Cause and effect diagram used to identify factors causing an overall effect.

five rights of delegation: Guidelines for delegation that include right task, right circumstance, right person, right direction or communication, and right supervision.

fixed cost: Expense that is constant and does not change with volume or patient acuity.

followership: An active, interpersonal process of participating by following a leader or manager.

foreseeability: The ability to presume that certain events are reasonably expected to cause certain specific results.

full-time equivalent (FTE): A full-time employee who works 40 hours per week, or 2080 hours annually.

goal: A specific intent or purpose that the unit desires to achieve within a 1-year time frame.

goal-setting: A process that formalizes the objectives of an organization.

group: A number of individuals assembled together or having a unifying relationship.

groupthink: Phenomenon that occurs when the desire for harmony and consensus overrides members’ rational efforts to appraise the situation.

holistic nursing: The practice that recognizes the totality of the human being, including the interconnectedness of body, mind, emotion, spirit, social/cultural, relationship, context, and environment.

human resource budget: Costs associated with persons needed to provide direct and indirect patient care.

hybrid structure: Hierarchical structure that provides a connection between program-specific services and improvements with division goals (seen in organizations that are growing in size and experiencing change).

implied consent: Nonverbal acceptance of a healthcare provider’s request to provide treatment.

improper delegation: Delegation at the wrong time, to the wrong person, or for the wrong reason.

incident report: Documentation that helps analyze problems so that solutions can be made to prevent the event from recurring.

indirect care: Measure of time spent on activities that are patient related but do not require hands-on care from the provider.

indirect delegation: Task completion dictated by agency policies, procedures, and protocols.

indirect expense: Cost for utilities and other items that are not directly related to patient care.

informed consent: Consent for treatment that occurs after competence, disclosure of information, comprehension, and voluntariness have been met.

injury: Physical injury after breach of standard that must be evident before a nurse can be found negligent in a court of law.


laissez-faire leadership: Leadership style in which leaders are passive and defer daily decision making to their subordinates.

leadership: The ability to influence others.

legitimate power: Power related to a person’s position in the organizational hierarchy.

liability: A nurse’s responsibility for his or her own conduct, duty to be performed, and responsibility for an action or outcome.

liable: Obligated according to law.

line authority: Linear chain-of-command through which tasks are directed.

malpractice: The failure of a nurse to act (practice) in accordance with current standards of practice or failure to anticipate consequences that a professional nurse with the same skills and expertise should anticipate.

management: Activities needed to design, organize, encourage, and control the personnel and operational resources needed to achieve organizational outcomes.

mandatory overtime: Requiring nurses to work beyond their scheduled shifts; refusal to do so could result in disciplinary action.

marketing: Analyzing, planning, implementing, and controlling programs to facilitate organizational goals achievement for individuals and communities.

matrix structure: Combination of centralized configurations and multiple project teams.

mentee: Typically, a younger, novice professional who seeks knowledge and guidance from an experienced expert.

mentor: An expert in a chosen field who can provide knowledge and guidance to fulfill a mentee’s learning needs.

mentoring program: Program that eases the transition from one professional role to another.

mission statement: Statement that reflects an organization’s unique purpose.

moral: The principle of doing right or good.

moral distress: Anxiety produced when nurses experience situations that involve ethical dilemmas.

moral framework: A framework used to guide ethical decision making.

negligence: Failure to exercise the level of care that a nurse using ordinary prudence, based on established standards, would exercise under the same or similar circumstances.

networking: A continuous means of initiating and continuing relationships through communication and information-sharing.

nonmaleficence: The duty to do no harm.

nonproductive hours: Hours represented by benefit time, such as sick time, vacation time, bereavement time, holidays, orientation time, and staff development and education time.

numerical scoring tool: Quantitative tool in which a rater assigns a number to criteria being measured and then a decision is made based on which option has the highest number.

nurse manager: Nurse with a 24-hour-a-day, 7-day-a-week responsibility for the management of one or more patient care units.

nurse practice act: A set of laws established by each state and the four U.S. territories to protect the public by regulating nursing practice.

nursing ethics: Ethical concerns that arise in nursing practice that nurses must manage relative to their own actions and interventions.

nursing hours per patient day (NHPPD): Measurement that quantifies nursing time available for patients by available nursing staff.

objectives: Succinct, measurable, and understood statements that help meet organizational goals.

ombudsman: A person employed to serve as an advocate for institutionalized elders, mainly in long-term care centers and nursing homes.

operating budget: Monetary account for income and expenses that are generated on a daily basis within each department in a healthcare organization.

organizational chart: A schematic representation of the formal organizational relationships of people within and across departments.

organizational leadership: Process of gaining leadership skills and attributes through involvement in professional nursing organizations.

over delegation: Too much authority given to subordinates for several wrong reasons.

overtime: Working over a scheduled shift through manager request or by volunteering.

paternalism: Situation in which a person makes a decision (assumes authority) for another person.

patient classification system: System that attempts to match the demands for nursing care with the supply of nurses.

payoff table: Tool used to make decisions based solely on fiscal impact.

philosophy: Core values of an individual, group, or organization.

plaintiff: Person bringing a lawsuit.
polarization: A group decision that is more extreme than a decision by individual group members.

portfolio: Compilation of professional work.

power: Ability to influence others.

preceptor: A person who provides guidance for a finite period of time to a lesser skilled individual.

primary assessment: Rapid assessment of airway, breathing, and circulation to identify immediate, life-threatening illnesses or injuries and deliver appropriate interventions.

prioritization: Deciding which needs or problems require immediate attention and which ones can be delayed until a later time because they are not as urgent.

prioritization of care: Ordering what aspects of care will be done first, with the least important tasks taking place after priority problems have been managed.

privacy: Protection of one’s solitude; the right to be left alone.

problem solving: Using an organized process to solve an issue.

productive hours: Hours that reflect the time a nurse works and is available for patient care.

professional organization (association): A coalition of nurses that provides networking opportunities for nurse leaders in the field to participate in health policy formulation, obtain continuing education opportunities, sharpen leadership skills, and shape the profession.

professional specialty organization: Organization that provides expert clinical, research, and leadership knowledge in a focused nursing field.

prototype system: Patient classification system that categorizes acuity into broad groups.

QSEN: Quality and safety education for nurses that addresses the concepts of patient-centered care, teamwork and collaboration, evidence-based practice, quality improvement, safety, and informatics.

referred power: Power associated with respect and admiration of an individual.

respect for others: All-encompassing ethical principle that acknowledges an individual’s right to make his or her own decisions and live by those decisions.

responsibility: State of being depended on.

reward power: Ability to grant favors.

ROLES: Acronym that stands for responsibilities, opportunities, lines of communication, expectations, and support.

role transition: A change in a person’s professional distinctiveness.

SBAR: Acronym that stands for situation, background, assessment, and recommendation; a technique that provides a framework for communication between members of the healthcare team about a patient’s condition.

secondary assessment: Assessment and evaluation of presenting and provoking factors, quality of pain, region and radiation, severity of pain, time, and treatment.

self-scheduling: Setup in which staff nurses on a unit collaborate and complete a work schedule.

shaken baby syndrome: Form of child abuse involving a collection of signs and symptoms that result from violent shaking of an infant or a toddler.

shared governance: Going beyond traditional democratic and participatory leadership models in interactions with nurses.

social loafing: Lack of responsibility felt for task completion in small work groups; least dysfunctional group pattern.

span of control: The number of subordinate’s one supervisor can effectively manage.

staffing: Hiring, orienting, and deploying qualified nurses to meet the demands for patient care.

staffing plan: A plan that depicts the number and category of nurses, shifts, average daily census and bed capacity, full-time equivalent (FTE) status (full-time or part-time), benefit FTEs, and the amount of direct care hours rendered per 24-hour period.

staff mix: The proportion of registered nurses, licensed practical nurses, and unlicensed assistive personnel in a specific health care unit.

staff position: Person who supports and serves as an advisor to persons in line positions.

state board of nursing: Governing body that has oversight for all aspects of nursing practice in a state or U.S. territory and whose secondary purpose is to protect the public.

statute of limitations: Time frame in which a plaintiff can bring suit against a defendant.

strategic plan: Deliberate organizational document developed to identify, garner consensus about, and communicate the direction of where an organization is going and to establish a time frame for goal attainment.

strategic planning process: Process involving the five phases of 1) environmental assessment; 2) mission statement, vision, philosophy, goals, and objectives; 3) identification of strategies; 4) implementation; and 5) evaluation.

syringe: A phenomenon in which teamwork produces extraordinary results that could not have been achieved by any one individual.

team: A number of people associated together in specific work or activities.

TOWS matrix: Acronym used to assess an organization’s threats, opportunities, weaknesses, and strengths.

triage: Initial assessment and sorting by acuity the immediate health problems or injuries of newly arriving patients.

triage assessment: Rapid, concise, and accurate account of a patient’s condition that involves a primary assessment of airway, breathing, and circulation within 5 minutes.

under delegation: Nondelegation of tasks (for several reasons), such as uncertainty of self and staff abilities, fear of resentment of delegated task, or taking on too much (nurse believes he or she is the best person for task completion).

unlicensed assistive personnel (UAP): Another term for unlicensed caregivers.

utilitarianism: Greatest good for the greatest number.

variable costs: Costs that fluctuate with volume, patient census, and complexity of care.

veracity: Truth-telling.

vision statement: Deliberate and future-oriented statement that describes the direction of an organization.
SELF-ASSESSMENT QUESTIONS

The following self-assessment questions are based on the learning objectives and are designed to evaluate your comprehension of the material and how well the content meets the educational objectives. Receive immediate feedback by comparing your answers to the Study Guide on page 85. This self-assessment is provided as a learning tool only.

You are not required to submit your answers to receive credit for the course.

ITEM #N1664 — 30 CONTACT HOURS

CHAPTER 1

1. A staff nurse states, “You can’t expect me to be a leader. I work as a full-time staff nurse on the night shift.” The astute nurse manager’s best response is
   a. “We expect you to have good organizational skills.”
   b. “A charge nurse position will be available soon.”
   c. “Leadership occurs at all levels of the organization.”
   d. “You will become a leader when you become certified.”

2. A difference between the personal traits of a nurse manager and a nurse leader is that the nurse leader
   a. focuses on tasks to accomplish a goal.
   b. focuses on relationships to accomplish a goal.
   c. interprets policy, procedures, and mandates.
   d. coordinates the monthly staffing schedule.

3. The leadership style consisting of a close, one-on-one relationship that encourages a team approach with staff nurses is known as
   a. democratic.
   b. bureaucratic.
   c. autocratic.
   d. laissez-faire.

4. A staff nurse is complaining that the new computer system for the attainment of laboratory results is too slow. An experienced democratic leader might
   a. ask if she would be willing to chair a task force to look at this issue.
   b. avoid interfering with the problem.
   c. tell the staff nurse that she will look into the issue.
   d. inform the staff nurse that this is not her area of responsibility.

5. A nurse manager who is a passive decision maker is best described as
   a. a follower.
   b. an autocratic leader.
   c. a democratic leader.
   d. a laissez-faire leader.

6. An important responsibility of an effective nurse manager is to maintain
   a. daily informal notes on each staff member.
   b. a safe work environment.
   c. a complete resource library for staff.
   d. a supply of snack food if staff are not able to take a meal break.

7. A staff nurse can demonstrate leadership skills in the work place by
   a. reporting underperforming staff to the nurse manager.
   b. reading journal articles.
   c. serving as a committee chair.
   d. socializing with other staff after work.

8. An important benefit of becoming a leader in a professional nursing organization is the opportunity to
   a. attend professional meetings at no cost.
   b. meet world renowned people.
   c. increase one’s salary significantly.
   d. network with national and international colleagues.

CHAPTER 2

9. A major medication error occurred on the neuro step-down unit. The nurse manager is accountable and, after assessing the patient, begins to collect data and problem solve the situation. The nurse manager’s actions best reflect
   a. insecurity.
   b. accountability.
   c. a lack of confidence in staff nurse capabilities.
   d. inexperience.

10. Conger’s Delegation Decision-Making Model arrives at making a delegation decision after reviewing
    a. personnel file, years of experience, and level of caregiver.
    b. tasks, problems, and level of caregiver.
    c. years of experience, tasks, and problems.
    d. error rate, tasks, and problems.

11. An LPN has been assigned the task of a complex dressing change. The LPN has previously demonstrated her skill in the task and the task is within her scope of practice according to her state nurse practice act and position description. Of the five rights of delegation, the one the charge nurse has followed in making this assignment is
    a. right communication.
    b. right supervision.
    c. right direction.
    d. right person.

12. Parameters for the registered nurse to use in determining his or her scope of practice and authority to delegate can be found in
    a. the nurse’s job description.
    b. the state nurse practice act.
    c. the employee handbook.
    d. the nursing unit’s policy and procedure manual.

13. When a nurse performs a patient care related task as written in the facility’s procedure manual, this is an example of
    a. under delegation.
    b. authoritative action.
    c. direct delegation.
    d. indirect delegation.

14. A charge nurse starts an IV line for an oncology patient who has experienced difficult IV starts in the past. Other nurses on the oncology unit could have started the IV. In this case, the charge nurse has clearly
    a. over delegated.
    b. violated assignment process.
    c. usurped her charge nurse role.
    d. under delegated.

15. Under delegation by nursing staff often results in
    a. stress and job dissatisfaction.
    b. decreased medication errors.
    c. higher quality direct patient care.
    d. improved relationships with UAP.
16. The first thing a triage ED nurse should do when a patient enters the triage area is
   a. collect the patient’s insurance information.
   b. complete a primary assessment.
   c. ask the patient if he or she has any allergies.
   d. obtain a set of vital signs.

17. An observation performed in a primary assessment is
   a. evaluation of pain.
   b. auscultation of bowel sounds.
   c. determination of a patent airway.
   d. cleaning of open wounds.

18. The focus of triage involves
   a. defining abuse.
   b. determining nurse credentials.
   c. determining liability.
   d. determining acuity levels.

19. A growing form of abuse inflicted by one child on another child is
   a. bullying.
   b. shaken baby syndrome.
   c. physical assault.
   d. physical neglect.

20. A parent who buys a six-pack of beer instead of food for his child is demonstrating
   a. abandonment.
   b. child abuse.
   c. alcoholism.
   d. physical neglect.

21. A competent decision maker
   a. organizes the process into defined steps.
   b. is highly educated and applies what he or she knows.
   c. is a linear thinker who does not deviate from the plan.
   d. is experienced in a specialty area.

22. A decision-making tool that uses a matrix to compare several items based on the same criteria is known as
   a. the PERT tool.
   b. numerical scoring.
   c. a decision grid.
   d. a decision tree.

23. The last step in the problem-solving process is to
   a. select multiple interventions.
   b. evaluate.
   c. establish alternatives.
   d. intervene.

24. The Fishbone diagram of cause and effect is most useful for
   a. the nurse leader to organize his or her thoughts.
   b. the staff nurse to organize patient care.
   c. brainstorming ideas in a group setting.
   d. presenting data to a group.

25. A nurse executive is planning to convene a group of nurses to develop an equitable policy for holiday schedules for all nursing units in the hospital. To ensure a good outcome, the committee should be composed of
   a. a diverse, representative mix of nurses.
   b. nurses with hospital seniority.
   c. one nurse from each unit.
   d. nurses who work full time.

26. Staff nurses can have an impact on reducing costs by managing
   a. medication costs.
   b. fixed costs.
   c. use of supplies.
   d. purchases of capital budget items.

27. The cost of equipment purchases that are expected to be used for more than a year would be reflected in
   a. healthcare agency costs.
   b. the capital budget.
   c. productivity measurements.
   d. operating budgets.

28. Productive hours are those hours associated with
   a. direct patient care.
   b. sick time.
   c. vacation time.
   d. paid holidays.

29. A healthcare agency’s variable costs are influenced by
   a. geographic location.
   b. patient volume.
   c. the facility’s quarterly newsletter.
   d. utility charges.

30. A medical unit has RN, LPN, LVN, and UAP staff members. This represents
   a. unit acuity.
   b. demands for nursing care.
   c. efficient staffing levels.
   d. staff mix.

31. Unit productivity can be measured by
   a. keeping track of sick time and vacation time used.
   b. comparing the number of licensed personnel to the number of unlicensed personnel.
   c. implementing a valid and reliable patient classification system.
   d. simply dividing the number of patients by the number of staff.

32. An objective patient classification system that quantifies a care indicator with a weight or number is called the
   a. factor system.
   b. prototype system.
   c. qualitative model.
   d. relative intensity model.

33. A subjective and descriptive patient classification system that categorizes acuity by broad groups in order to predict care needs is known as the
   a. factor system.
   b. prototype system.
   c. qualitative model.
   d. relative intensity model.

34. A nurse manager of a cardiac unit completes the staffing schedule for her unit. The key advantage of using a decentralized scheduling process over a centralized process is that the nurse manager
   a. is aware of external staffing pool nurses.
   b. is the person most informed about the unit’s staffing plan.
   c. can develop the schedule quickly and easily.
   d. is personally attached to the staff.

Chapter 5

26. Staff nurses can have an impact on reducing costs by managing
   a. medication costs.
   b. fixed costs.
   c. use of supplies.
   d. purchases of capital budget items.

27. The cost of equipment purchases that are expected to be used for more than a year would be reflected in
   a. healthcare agency costs.
   b. the capital budget.
   c. productivity measurements.
   d. operating budgets.

28. Productive hours are those hours associated with
   a. direct patient care.
   b. sick time.
   c. vacation time.
   d. paid holidays.

29. A healthcare agency’s variable costs are influenced by
   a. geographic location.
   b. patient volume.
   c. the facility’s quarterly newsletter.
   d. utility charges.

30. A medical unit has RN, LPN, LVN, and UAP staff members. This represents
   a. unit acuity.
   b. demands for nursing care.
   c. efficient staffing levels.
   d. staff mix.

31. Unit productivity can be measured by
   a. keeping track of sick time and vacation time used.
   b. comparing the number of licensed personnel to the number of unlicensed personnel.
   c. implementing a valid and reliable patient classification system.
   d. simply dividing the number of patients by the number of staff.

32. An objective patient classification system that quantifies a care indicator with a weight or number is called the
   a. factor system.
   b. prototype system.
   c. qualitative model.
   d. relative intensity model.

33. A subjective and descriptive patient classification system that categorizes acuity by broad groups in order to predict care needs is known as the
   a. factor system.
   b. prototype system.
   c. qualitative model.
   d. relative intensity model.

34. A nurse manager of a cardiac unit completes the staffing schedule for her unit. The key advantage of using a decentralized scheduling process over a centralized process is that the nurse manager
   a. is aware of external staffing pool nurses.
   b. is the person most informed about the unit’s staffing plan.
   c. can develop the schedule quickly and easily.
   d. is personally attached to the staff.
38. The best way for a hospital to inform the public of its key programs would be to develop a
   a. marketing plan.
   b. volunteer work group.
   c. budget strategy.
   d. fund-raising program.

39. Regional Hospital is located in an urban area that has several schools of nursing. The hospital needs to attract nurses to work at the facility, so it offers a school-loan forgiveness program, an extensive 3-month orientation, and a $3,000 sign-on bonus. These strategies represent
   a. desperation for the hospital staffing needs.
   b. sound fiscal planning.
   c. a marketing plan to attract nurses.
   d. attention to the internal environment.

CHAPTER 7

40. An illustration that represents personnel in a healthcare agency and lines of authority is known as
   a. shared governance.
   b. an organizational chart.
   c. a hybrid structure.
   d. unspoken organizational power lines.

41. An organizational chart shows the positions and relationships within an organization. Split or dotted lines on an organizational chart represent
   a. role confusion.
   b. line positions.
   c. staff positions.
   d. centralization.

42. Staff authority positions differ from line authority positions in that staff positions
   a. are responsible for carrying out direct patient care.
   b. provide support to people in line positions.
   c. are synonymous with staff nurses.
   d. are accountable for achieving unit or department objectives.

43. A hierarchal organizational structure arranged by specialty areas and depicted as a tall structure is known as
   a. centralized structure.
   b. decentralized structure.
   c. hybrid structure.
   d. shared governance.

44. A unique characteristic of the matrix organizational structure is that
   a. it inhibits innovation and cooperation among workers.
   b. it is commonly used in small healthcare organizations.
   c. individuals may report to more than one manager.
   d. it promotes autonomous decision making.

CHAPTER 8

45. Members of a local Baptist church represent a(n)
   a. common purpose.
   b. group.
   c. exclusive club.
   d. team.

46. June is described as an excellent communicator and good listener and maintains a focus on goal attainment. These attributes are qualities of
   a. experienced nurses.
   b. all healthcare workers.
   c. a good team member.
   d. people with graduate degrees.

47. A unit manager assigns a committee of nurses to develop a protocol for electronic charting. The nurses meet to review the directive, engage in social conversations, and review some issues taking place on their assigned unit. A committee chairperson has not been selected and they are 2 months into the project. The dysfunctional group pattern exhibited by this group is
   a. polarization.
   b. social loafing.
   c. groupthink.
   d. scapegoating.

48. Autonomy of nurse practice, focused committees that evaluate quality care and patient outcomes, and an organization that values education reflect the concept of
   a. shared governance.
   b. fiscal accountability.
   c. employee-recognition programs.
   d. centralized management.

49. A unit manager is preparing for the monthly staff meeting. To ensure that all topics are covered within the 1-hour time frame, the nurse manager should
   a. leave the last 10 minutes of the meeting open to ensure agenda items are addressed.
   b. not allow staff dialogue during the unit meeting.
   c. be the only person addressing the group.
   d. set a timed agenda.

CHAPTER 9

50. The Institute of Medicine states that the practice of patient-centered care involves
   a. an appreciation of the whole person as a biological human being.
   b. healthcare providers respecting patients’ preferences and requesting input from patients on the education and support they need.
   c. healthcare providers treating the disease and offering conventional medicine.
   d. healthcare providers focusing on curing the disease, while requesting input from allied health professionals.

51. One way for a nurse manager to empower nurses to practice patient-centered care is to create a
   a. culture that supports the concepts of biomedical care.
   b. environment of dictatorial decision making.
   c. unifocal vision of patient-centered care.
   d. culture of patient-centered care.

52. An example of patient empowerment is when a nurse
   a. explains to a patient that the doctor has ordered medications to be given at 9 a.m.
   b. enters a patient’s room and explains to the patient that pain medicine is ordered to be given at 9 p.m.
   c. asks a patient when he usually takes his medicine at home and tells him it will be given to him at that time.
   d. explains to the wife of a patient that he will be receiving his usual medications according to the hospital’s schedule.

53. The phase of therapeutic communication when emotions are increased is the
   a. escalation phase.
   b. orientation phase.
   c. de-escalation phase.
   d. outcome phase.

54. A disadvantage of electronic health records related to patient-centered care is
   a. resistance by staff to new documentation systems.
   b. concerns with privacy of information.
   c. increased time needed for documentation.
   d. issues with the accuracy of the data.

CHAPTER 10

55. Two nurses have different opinions on the best way to make daily assignments. This example represents the type of conflict known as
   a. organizational conflict.
   b. intragroup conflict.
   c. interpersonal conflict.
   d. intrapersonal conflict.

56. Because of inconsistencies when rating wounds, there has been an increase in pressure ulcers on a medical-surgical hospital unit. The nurses on the unit come together to develop a wound care and rating protocol. This strategy of managing conflict reflects a
   a. win-win strategy.
   b. no-win strategy.
   c. win-lose strategy.
   d. lose-lose strategy.
57. Nurse Smith, who works 12-hour shifts, complains to her coworkers that she feels it is unfair that nurses who work 8-hour shifts receive overtime but nurses who work 12-hour shifts are not permitted to receive overtime. Her coworkers suggest that she bring this problem up at the next staff meeting. Her response is “never mind.” If something doesn’t change by next year, she might bring it up then. Nurse Smith’s mode of conflict resolution reflects
   a. competing.
   b. avoiding.
   c. negotiating.
   d. collaborating.

58. Nurse Johnson is working 20 hours overtime each week because her husband recently lost his job. She is feeling symptoms of prolonged stress: lack of desire to go to work and uncontrolled crying. The most effective strategy to help Nurse Johnson manage her stress is
   a. better time management.
   b. self-management.
   c. hypnosis.
   d. counseling.

59. Nurse Davis, a new unit manager, is trying to prioritize her daily goals. She sets up an action plan to work part of each morning on one of her large projects. This is an example of
   a. self-management.
   b. managing conflict.
   c. burnout.
   d. time management.

**CHAPTER 11**

60. The ability to influence others is known as
   a. conflict.
   b. resilience.
   c. power.
   d. perseverance.

61. John is certified as an infusion therapist. A nurse manager invites John to present a talk on starting difficult intravenous lines. The nurse manager recognizes John’s
   a. expert power.
   b. legitimate power.
   c. referent power.
   d. connection power.

62. Sally is a nursing supervisor. The power she has related to her position within the organization is referred to as
   a. referent power.
   b. legitimate power.
   c. connection power.
   d. charismatic power.

63. Nurses who are actively involved in decision making, enhancing quality care, and initiating actions that promote positive patient outcomes, reflect
   a. good management.
   b. higher education.
   c. team spirit.
   d. empowered environments.

64. Strategies for developing a power image include
   a. always using coercive power and control to achieve goals.
   b. always answering a question, even if it requires guessing.
   c. being confident, polished, and informed.
   d. always saying what is on your mind so people know you are genuine.

65. All nurses should be familiar with the nurse practice act in the state in which they practice because it serves to
   a. convey which nursing programs are best in the state.
   b. regulate and define nursing practice for the protection of the public.
   c. report individual license scores to consumers of healthcare services.
   d. provide information on license renewal.

66. A nurse practice act is a form of
   a. civil law.
   b. criminal law.
   c. ANA standards of practice.

67. A primary purpose of state boards of nursing is to
   a. serve as an advocate for nurses.
   b. protect the public.
   c. provide counsel for patients.
   d. serve as a resource for student nurses.

68. A nurse takes the blood pressure (BP) of a hypertensive patient, and the BP is 240/110 mm Hg. The nurse notes that a UAP took the BP 5 minutes earlier and documented the BP as 104/68 mm Hg. The nurse questions the discrepancy, and the UAP responds, “I’m sorry, I had so many vital signs to take that I just made them up.” The type of error that occurred in this case is an error of
   a. commission.
   b. slander.
   c. res ipsa loquitur.
   d. omission.

69. Duty, breach of duty, foreseeability, causation, injury, and damages are
   a. the six rights of patient care.
   b. the elements of malpractice.
   c. competence acts.
   d. examples of patient rights legislation.

70. A statute of limitations is
   a. related to comprehension.
   b. related to foreseeability.
   c. related to patient competency and guardianship.
   d. the length of time allowed by law for a plaintiff to bring suit against a defendant.

71. A patient is scheduled for a surgical hip repair. The surgeon explains the benefits and risks of the operation to the patient in a language the patient understands. After the patient expresses his understanding, he
   a. can go directly into surgery.
   b. must complete a survey that represents his understanding of the surgery.
   c. can sign the informed consent form for surgery.
   d. must explain the procedure to the nurse.

72. The federal legislation that protects a person from being discriminated against based on national origin is the
   b. Americans with Disabilities Act.
   c. Civil Rights Act.
   d. Occupational Safety and Health Act.

73. A nurse floats to the medical unit and finds that soiled linens are hanging off of the hamper and gloves are not in convenient locations. The nurse recognizes the need to intervene and notifies the nurse manager. To ensure employee protection, the nurse manager
   a. calls housekeeping.
   b. reviews OSHA standards with the staff.
   c. writes up the nurse who did not empty the hamper on her scheduled break.
   d. directs the nursing assistant to empty the hamper and gloves in the hamper in a timely manner.

**CHAPTER 12**

74. A conflict between two or more ethical principles, for which there is no right or wrong decision, is known as
   a. a moral.
   b. a nursing ethic.
   c. an ethical dilemma.
   d. justice.
75. A nurse who shares information about home healthcare agency options with a patient discharged after a total hip arthroplasty, but withholds information about long-term care placement, is a. limiting patient autonomy. b. exercising veracity. c. cognizant of practicing nonmaleficence. d. displaying egoism.

76. The ethical principle of autonomy underlies the a. right to fair and equitable treatment. b. nurse’s obligation to always tell the truth. c. nurse’s obligation to always fulfill one’s promise. d. right to choose what will happen to one’s own person.

77. A system of ethical decision making that is based on the “greatest good” principle is called a. utilitarianism. b. egoism. c. freedom. d. autonomy.

78. A patient is morbidly obese and needs to be transferred to a stretcher. Two staff nurses are available, but one insists that she must first get a third person to help with the transfer. She states, “Someone could get injured if we don’t get more help.” Avoiding the risk of harm or getting hurt is an example of the ethical principle known as a. fidelity. b. veracity. c. nonmaleficence. d. justice.

79. Suzy has advanced cancer. The only treatment alternative available to her is a rare, costly, experimental bone marrow transfusion with a 10% success rate. Her insurance company refuses to authorize payment for the $200,000 procedure, arguing that the money could be better spent providing well-baby screenings for 2,200 residents in the community. This resource allocation reflects the ethical decision-making principle of a. autonomy. b. nonmaleficence. c. paternalism. d. utilitarianism.

80. A nurse encounters a potential ethical dilemma. The document that can best provide ethical standards and guidance to the nurse is the a. Nurse Practice Act. b. ANA Code of Ethics for Nurses. c. agency protocols. d. hospital policy.


82. When using the MORAL Model of Ethical Decision Making, the nurse should first a. collect relevant data about the ethical circumstance. b. develop a decision-making grid. c. outline available options for action. d. determine a course of action.

83. When a charge nurse is confronted with an ethical dilemma regarding a patient situation and he or she does not know how to manage the situation, the most appropriate action would be to consult with the facility’s a. chief of staff. b. medical director. c. closest staff nurse. d. ethics committee.

Chapter 14

84. The transition from the role of a staff nurse in acute care to critical care can best be eased by providing a. a higher salary. b. a mentorship program. c. an instruction manual. d. a schedule that rotates shifts.

85. The type of program that best eases the transition from student to professional nurse is a. leadership correspondence. b. virtual hospital software. c. mentorship. d. hospital orientation.

86. A basic trait of an ideal “mentee” is someone who a. lacks self-confidence. b. avoids taking risks. c. is a concrete thinker. d. is hungry for knowledge.

87. One of the most notable characteristics of mentors is that they are a. professors emeritus. b. in mid-career. c. experts in their chosen fields. d. certified in nursing administration.

88. One way in which preceptorships differ from mentorships is that a. preceptorships are found in many types of industries, whereas mentoring programs are found exclusively in schools of nursing. b. preceptors are typically more experienced than mentors. c. preceptorships are for a finite amount of time, whereas mentorships can last for many years. d. preceptors volunteer and select their students, whereas mentors are assigned students.

89. A major benefit for the preceptor in guiding a new nurse is a. being seen in a senior role by physicians. b. taking a smaller patient load. c. serving as a preceptor for an extensive period of time. d. having the opportunity to serve as a role model in a teaching role.

90. Nurse managers commonly serve as coaches to new nurses assigned to their units. The major goal of the coaching relationship is to promote a. optimal clinical performance. b. retention within the workforce. c. a reduction in the rate of errors. d. increased job satisfaction.

91. One of the positive aspects of performance appraisals is that they a. point out system-wide medication error rates. b. can motivate employees and enhance performance. c. compare employees to each other. d. are only done once a year.

92. A nursing portfolio a. is synonymous with a professional résumé. b. should contain a copy of your birth certificate and driver’s license. c. should list acknowledgements anonymously to protect privacy. d. highlights your competencies, educational achievements, and skills.

Chapter 15

93. Professional nursing organizations, as a whole, are best defined as a. research groups that focus on specific topics of interest. b. coalitions of nurses that provide networking opportunities. c. political lobbying groups that promote fair labor laws for nurses. d. clinical practice specialty groups that require their members to be certified.
94. Which statement about nurses and professional nursing organizations is most accurate?
a. A nurse should join one professional organization and give his or her total commitment to that organization.
b. Professional organizations impact health policy, provide continuing education, increase leadership skills, and shape the profession.
c. A nurse should join professional organizations to round out his or her resume.
d. A nurse should join as many professional organizations as he or she can afford to increase opportunities for promotion.

95. A nurse states, “I am so busy raising three young children younger than 8 and caring for my aging grandmother that I cannot see the point of maintaining my membership in the ANA.” An appropriate response by the nurse manager would be
a. “I can see how the dues you pay could be better utilized in your family budget.”
b. “Consider hiring caregivers because active involvement in a professional organization is important to your career.”
c. “You can always rejoin the ANA after your home situation improves.”
d. “As a dues-paying member, you support the work of ANA and invest in your career.”

96. One benefit of belonging to a professional organization is specialty certification. Certification in a nursing specialty field is designed to recognize
a. nurse practitioners exclusively.
b. continued competency for nursing licensure.
c. advanced knowledge beyond nursing licensure.
d. nurses holding graduate degrees.

97. Three applicants are interested in the oncology nurse educator position at the local hospital. One of the applicants asks her mentor how to stand out over the other candidates. The mentor shares that an excellent mechanism to demonstrate nursing expertise is to
a. obtain certification in one’s specialty field.
b. join one of the nursing division’s committees.
c. have a low rate of medication and procedural errors.
d. be willing to work overtime whenever asked.

98. An oncology staff nurse is very interested in the topic of breakthrough pain. She tells her nurse manager that she would like to gain experience with formal presentation skills. The best response from the nurse manager to encourage the staff nurse’s development of presentation skills would be to recommend that the staff nurse
a. transfer to the palliative care unit.
b. start by doing a poster presentation at the local Oncology Nursing Society meeting.
c. practice speaking at home in front of a mirror.
d. take a position in the hospital’s education department.

99. A new nurse manager wants to excel in the middle management role, so she joins the American Organization of Nurse Executives, which offers many benefits to its members. A major benefit for the new nurse manager is
a. resumé building.
b. networking opportunities.
c. meeting other new orthopedic nurses.
d. promotion opportunities.

100. John is a staff nurse on a cardiac telemetry unit and is a leader on his unit. One characteristic that demonstrates professionalism on John’s part is that he
a. works 72 hours per 2-week pay period.
b. is certified in basic life support.
c. frequently volunteers to work overtime.
d. is pursuing a Bachelor of Science in Nursing degree at the local university.
STUDY GUIDE

Evaluate your comprehension of the course content by comparing your answers to the self-assessment questions below. We encourage you to apply what you have learned to your clinical practice.

ITEM #N1664 — 30 CONTACT HOURS

CHAPTER 1

1. A staff nurse states, “You can’t expect me to be a leader. I work as a full-time staff nurse on the night shift.” The astute nurse manager’s best response is
   a. “Leadership occurs at all levels of the organization.”
   b. “You can’t expect me to be a leader. I work as a full-time staff nurse on the night shift.”
   c. “Leadership occurs at all levels of the organization.”

2. A difference between the personal traits of a nurse manager and a nurse leader is that the nurse leader
   a. focuses on relationships to accomplish a goal.
   b. focuses on relationships to accomplish a goal.
   c. focuses on relationships to accomplish a goal.
   d. a laissez-faire leader.

3. The leadership style consisting of a close, one-on-one relationship that encourages a team approach with staff nurses is known as
   a. democratic.
   b. a safe work environment.
   c. serving as a committee chair.

4. A staff nurse is complaining that the new computer system for the attainment of laboratory results is too slow. An experienced democratic leader might
   a. ask if she would be willing to chair a task force to look at this issue.
   b. focus on relationships to accomplish a goal.
   c. focus on relationships to accomplish a goal.
   d. a laissez-faire leader.

5. A nurse manager who is a passive decision maker is best described as
   a. ask if she would be willing to chair a task force to look at this issue.
   b. a safe work environment.
   c. serving as a committee chair.
   d. a laissez-faire leader.

6. An important responsibility of an effective nurse manager is to maintain
   a. focus on relationships to accomplish a goal.
   b. a safe work environment.
   c. focus on relationships to accomplish a goal.
   d. a laissez-faire leader.

7. A staff nurse can demonstrate leadership skills in the work place by
   a. focus on relationships to accomplish a goal.
   b. a safe work environment.
   c. focus on relationships to accomplish a goal.
   d. a laissez-faire leader.

8. An important benefit of becoming a leader in a professional nursing organization is the opportunity to
   a. focus on relationships to accomplish a goal.
   b. a safe work environment.
   c. focus on relationships to accomplish a goal.
   d. network with national and international colleagues.

9. A major medication error occurred on the neuro step-down unit. The nurse manager is accountable and, after assessing the patient, begins to collect data and problem solve the situation. The nurse manager’s actions best reflect
   a. accountability.
   b. focus on relationships to accomplish a goal.
   c. focus on relationships to accomplish a goal.

10. Conger’s Delegation Decision-Making Model arrives at making a delegation decision after reviewing
    a. tasks, problems, and level of caregiver.
    b. tasks, problems, and level of caregiver.
    c. tasks, problems, and level of caregiver.
    d. right person.

11. An LPN has been assigned the task of a complex dressing change. The LPN has previously demonstrated her skill in the task and the task is within her scope of practice according to her state nurse practice act and position description. Of the five rights of delegation, the one the charge nurse has followed in making this assignment is
    a. stress and job dissatisfaction.
    b. a safe work environment.
    c. serving as a committee chair.

12. Parameters for the registered nurse to use in determining his or her scope of practice and authority to delegate can be found in
    a. the state nurse practice act.
    b. focus on relationships to accomplish a goal.
    c. focus on relationships to accomplish a goal.
    d. a laissez-faire leader.

13. When a nurse performs a patient care related task as written in the facility’s procedure manual, this is an example of
    a. stress and job dissatisfaction.
    b. a safe work environment.
    c. focus on relationships to accomplish a goal.
    d. indirect delegation.

14. A charge nurse starts an IV line for an oncology patient who has experienced difficult IV starts in the past. Other nurses on the oncology unit could have started the IV. In this case, the charge nurse has clearly
    a. stress and job dissatisfaction.
    b. a safe work environment.
    c. focus on relationships to accomplish a goal.
    d. under delegated.

15. Under delegation by nursing staff often results in
    a. stress and job dissatisfaction.
    b. a safe work environment.
    c. focus on relationships to accomplish a goal.
    d. a laissez-faire leader.

CHAPTER 2

16. The first thing a triage ED nurse should do when a patient enters the triage area is
    a. complete a primary assessment.
    b. a safe work environment.
    c. focus on relationships to accomplish a goal.

17. An observation performed in a primary assessment is
    a. complete a primary assessment.
    b. focus on relationships to accomplish a goal.
    c. determination of a patent airway.

18. The focus of triage involves
    a. complete a primary assessment.
    b. focus on relationships to accomplish a goal.
    c. determination of a patent airway.

19. A growing form of abuse inflicted by one child on another child is
    a. bullying.
    b. stress and job dissatisfaction.
    c. determine acuity levels.

20. A parent who buys a six-pack of beer instead of food for his child is demonstrating
    a. bullying.
    b. physical neglect.
    c. determination of a patent airway.

CHAPTER 3

21. A competent decision maker
    a. organizes the process into defined steps.
    b. complete a primary assessment.
    c. focus on relationships to accomplish a goal.

22. A decision-making tool that uses a matrix to compare several items based on the same criteria is known as
    a. the state nurse practice act.
    b. focus on relationships to accomplish a goal.
    c. a decision grid.

23. The last step in the problem-solving process is to
    a. organizes the process into defined steps.
    b. evaluate.
    c. brainstorming ideas in a group setting.

24. The Fishbone diagram of cause and effect is most useful for
    a. organizes the process into defined steps.
    b. brainstorming ideas in a group setting.
    c. a decision grid.

25. A nurse executive is planning to convene a group of nurses to develop an equitable policy for holiday schedules for all nursing units in the hospital. To ensure a good outcome, the committee should be composed of
    a. a diverse, representative mix of nurses.
    b. complete a primary assessment.
    c. determination of a patent airway.

CHAPTER 4

26. Staff nurses can have an impact on reducing costs by managing
    a. a diverse, representative mix of nurses.
    b. evaluate.
    c. use of supplies.

27. The cost of equipment purchases that are expected to be used for more than a year would be reflected in
    a. a diverse, representative mix of nurses.
    b. the capital budget.
    c. determine acuity levels.

28. Productive hours are those hours associated with
    a. a diverse, representative mix of nurses.
    b. the capital budget.
    c. implement a valid and reliable patient classification system.

29. A healthcare agency’s variable costs are influenced by
    a. a diverse, representative mix of nurses.
    b. determine acuity levels.
    c. implement a valid and reliable patient classification system.

30. A medical unit has RN, LPN, LVN, and UAP staff members. This represents
    a. a diverse, representative mix of nurses.
    b. the capital budget.
    c. a decision grid.

31. A unit productivity can be measured by
    a. a diverse, representative mix of nurses.
    b. evaluate.
    c. use of supplies.

32. An objective patient classification system that quantifies a care indicator with a weight or number is called the
    a. a diverse, representative mix of nurses.
    b. determine acuity levels.
    c. implement a valid and reliable patient classification system.
Chapter 6

35. Strategic planning mirrors the nursing process.

36. The first phase of strategic planning using the TOWS matrix is environmental assessment.

37. The phase of the strategic planning process in which the healthcare team develops a comprehensive plan to meet the objectives of the organization is known as Phase III identification of strategies.

38. The best way for a hospital to inform the public of its key programs would be to develop a marketing plan.

39. Regional Hospital is located in an urban area that has several schools of nursing. The hospital needs to attract nurses to work at the facility, so it offers a school-loan forgiveness program, an extensive 3-month orientation, and a $3,000 sign-on bonus. These strategies represent a marketing plan to attract nurses.

Chapter 7

40. An illustration that represents personnel in a healthcare agency and lines of authority is known as an organizational chart.

41. An organizational chart shows the positions and relationships within an organization. Split or dotted lines on an organizational chart represent staff positions.

42. Staff authority positions differ from line authority positions in that staff positions provide support to people in line positions.

43. A hierarchal organizational structure arranged by specialty areas and depicted as a tall structure is known as centralized structure.

44. A unique characteristic of the matrix organizational structure is that individuals may report to more than one manager.

Chapter 8

45. Members of a local Baptist church represent a(n) group.

46. June is described as an excellent communicator and good listener and maintains a focus on goal attainment. These attributes are qualities of a good team member.

47. A unit manager assigns a committee of nurses to develop a protocol for electronic charting. The nurses meet to review the directive, engage in social conversations, and review some issues taking place on their assigned unit. A committee chairperson has not been selected and they are 2 months into the project. The dysfunctional group pattern exhibited by this group is social loafing.

48. Autonomy of nurse practice, focused committees that evaluate quality care and patient outcomes, and an organization that values education reflect the concept of shared governance.

49. A unit manager is preparing for the monthly staff meeting. To ensure that all topics are covered within the 1-hour time frame, the nurse manager should set a timed agenda.

Chapter 9

50. The Institute of Medicine states that the practice of patient-centered care involves healthcare providers respecting patients’ preferences and requesting input from patients on the education and support they need.

51. One way for a nurse manager to empower nurses to practice patient-centered care is to create a culture of patient-centered care.

52. An example of patient empowerment is when a nurse asks a patient when he usually takes his medicine at home and tells him it will be given to him at that time.

53. The phase of therapeutic communication when emotions are increased is the escalation phase.

54. A disadvantage of electronic health records related to patient-centered care is concerns with privacy of information.

Chapter 10

55. Two nurses have different opinions on the best way to make daily assignments. This example represents the type of conflict known as interpersonal conflict.

56. Because of inconsistencies when rating wounds, there has been an increase in pressure ulcers on a medical-surgical hospital unit. The nurses on the unit come together to develop a wound care and rating protocol. This strategy of managing conflict reflects a win-win strategy.

57. Nurse Smith, who works 12-hour shifts, complains to her coworkers that she feels it is unfair that nurses who work 8-hour shifts receive overtime but nurses who work 12-hour shifts are not permitted to receive overtime. Her coworkers suggest that she bring this problem up at the next staff meeting. Her response is “never mind.” If something doesn’t change by next year, she might bring it up then. Nurse Smith’s mode of conflict resolution reflects avoiding.

58. Nurse Johnson is working 20 hours overtime each week because her husband recently lost his job. She is feeling symptoms of prolonged stress: lack of desire to go to work and uncontrolled crying. The most effective strategy to help nurse Johnson manage her stress is counseling.

59. Nurse Davis, a new unit manager, is trying to prioritize her daily goals. She sets up an action plan to work part of each morning on one of her large projects. This is an example of time management.

Chapter 11

60. The ability to influence others is known as power.

61. John is certified as an infusion therapist. A nurse manager invites John to present a talk on starting difficult intravenous lines. The nurse manager recognizes John’s expert power.

62. Sally is a nursing supervisor. The power she has related to her position within the organization is referred to as legitimate power.

63. Nurses who are actively involved in decision making, enhancing quality care, and initiating actions that promote positive patient outcomes, reflect empowered environments.
64. Strategies for developing a power image include
   a. being confident, polished, and informed.

65. All nurses should be familiar with the nurse practice act in the state in which they practice because it serves to
   b. regulate and define nursing practice for the protection of the public.

66. A nurse practice act is a form of
   a. civil law.
   b. protect the public.

67. A primary purpose of state boards of nursing is to
   b. protect the public.

68. A nurse takes the blood pressure (BP) of a hypertensive patient, and the BP is 240/110 mm Hg. The nurse notes that a UAP took the BP 5 minutes earlier and documented the BP as 104/68 mm Hg. The nurse questions the discrepancy, and the UAP responds, “I’m sorry. I had so many vital signs to take that I just made them up.” The type of error that occurred in this case is an error of
   a. commission.

69. Duty, breach of duty, foreseeability, causation, injury, and damages are
   b. the elements of malpractice.

70. A statute of limitations is
   d. the length of time allowed by law for a plaintiff to bring suit against a defendant.

71. A patient is scheduled for a surgical hip repair. The surgeon explains the benefits and risks of the operation to the patient in a language the patient understands. After the patient expresses his understanding, he
   b. can sign the informed consent form for surgery.

72. The federal legislation that protects a person from being discriminated against based on national origin is the
   c. Civil Rights Act.

73. A nurse floats to the medical unit and finds that soiled linens are hanging off of the hamper and gloves are not in convenient locations. The nurse recognizes the need to intervene and notifies the nurse manager. To ensure employee protection, the nurse manager
   b. reviews OSHA standards with the staff.

74. A conflict between two or more ethical principles, for which there is no right or wrong decision, is known as
   c. an ethical dilemma.

75. A nurse who shares information about home healthcare agency options with a patient discharged after a total hip arthroplasty, but withholds information about long-term care placement, is
   a. limiting patient autonomy.

76. The ethical principle of autonomy underlies the
   d. right to choose what will happen to one’s own person.

77. A system of ethical decision making that is based on the “greatest good” principle is called
   a. utilitarianism.

78. A patient is morbidly obese and needs to be transferred to a stretcher. Two staff nurses are available, but one insists that she must first get a third person to help with the transfer. She states, “Someone could get injured if we don’t get more help.” Avoiding the risk of harm or getting hurt is an example of the ethical principle known as
   c. nonmaleficence.

79. Suzy has advanced cancer. The only treatment alternative available to her is a rare, costly, experimental bone marrow transfection with a 10% success rate. Her insurance company refuses to authorize payment for the $200,000 procedure, arguing that the money could be better spent providing well-baby screenings for 2,200 residents in the community. This resource allocation reflects the ethical decision-making principle of
   d. utilitarianism.

80. A nurse encounters a potential ethical dilemma. The document that can best provide ethical standards and guidance to the nurse is the
   b. ANA Code of Ethics for Nurses.

81. Strong parallels exist between the AMA Code of Ethics and the
   a. ANA Code of Ethics for Nurses.

82. When using the MORAL Model of Ethical Decision Making, the nurse should first
   a. collect relevant data about the ethical circumstance.

83. When a charge nurse is confronted with an ethical dilemma regarding a patient situation and he or she does not know how to manage the situation, the most appropriate action would be to consult with the facility’s
   d. ethics committee.

84. The transition from the role of a staff nurse in acute care to critical care can best be eased by providing
   b. a mentorship program.

85. The type of program that best eases the transition from student to professional nurse is
   c. mentorship.

86. A basic trait of an ideal “mentee” is someone who
   d. is hungry for knowledge.

87. One of the most notable characteristics of mentors is that they are
   c. experts in their chosen fields.

88. One way in which preceptorships differ from mentorships is that
   c. preceptorships are for a finite amount of time, whereas mentorships can last for many years.

89. A major benefit for the preceptor in guiding a new nurse is
   d. having the opportunity to serve as a role model in a teaching role.

90. Nurse managers commonly serve as coaches to new nurses assigned to their units. The major goal of the coaching relationship is to promote
   a. optimal clinical performance.

91. One of the positive aspects of performance appraisals is that they
   b. can motivate employees and enhance performance.

92. A nursing portfolio
   d. highlights your competencies, educational achievements, and skills.

93. Professional nursing organizations, as a whole, are best defined as
   b. coalitions of nurses that provide networking opportunities.

94. Which statement about nurses and professional nursing organizations is most accurate?
   b. Professional organizations impact health policy, provide continuing education, increase leadership skills, and shape the profession.

95. A nurse states, “I am so busy raising three young children younger than 8 and caring for my aging grandmother that I cannot see the point of maintaining my membership in the ANA.” An appropriate response by the nurse manager would be
   d. “As a dues-paying member, you support the work of ANA and invest in your career.”

96. One benefit of belonging to a professional organization is specialty certification. Certification in a nursing specialty field is designed to recognize
   c. advanced knowledge beyond nursing licensure.
97. Three applicants are interested in the oncology nurse educator position at the local hospital. One of the applicants asks her mentor how to stand out over the other candidates. The mentor shares that an excellent mechanism to demonstrate nursing expertise is to
   a. obtain certification in one’s specialty field.

98. An oncology staff nurse is very interested in the topic of breakthrough pain. She tells her nurse manager that she would like to gain experience with formal presentation skills. The best response from the nurse manager to encourage the staff nurse’s development of presentation skills would be to recommend that the staff nurse
   b. start by doing a poster presentation at the local Oncology Nursing Society meeting.

99. A new nurse manager wants to excel in the middle management role, so she joins the American Organization of Nurse Executives, which offers many benefits to its members. A major benefit for the new nurse manager is
   b. networking opportunities.

100. John is a staff nurse on a cardiac telemetry unit and is a leader on his unit. One characteristic that demonstrates professionalism on John’s part is that he
    d. is pursuing a Bachelor of Science in Nursing degree at the local university.

Course Completion Code: 30TCC1
You must enter this code to receive your certificate of completion.