Quality and Safety Matters

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The Future of Nursing

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Class of 2020

The 2010 Affordable Care Act prompted increased focus on the American health care system and the roles of health care professionals, suggesting standardizing higher education for nurses as a mechanism to improve the quality, safety, and accessibility of care. The increasing age and diversity of the American population seeking health care is a driving force for this change. An increase in chronic diseases such as diabetes, hypertension, cardiovascular disease, and mental health conditions have become the predominant focus of health care, but the current system is directed at treating acute illnesses in a narrow contextual spectrum, neglecting current health care needs. The current changes in the American population, coupled with the normalization of chronic diseases, calls for nurses with skills and knowledge to provide exceptional care under evolving circumstances. As patients' illnesses become more complex, the new standard needs to become higher education with a holistic approach that incorporates skills of leadership, systems improvement, and teamwork to create an environment conducive to preparing nurses to successfully care for patients in the current health care climate.

An improved education system highlighting the importance of community settings, public health, and long-term care is the first step in preparing nurses to address the diverse needs of the American population. Understanding different aspects of the health care team, the process and accessibility of social service programs, and the implications of health policies will strengthen the effectiveness of care and ensure better long-term outcomes for patients. Nursing school curricula should be revised to address the new context of health care. Competencies in nursing schools should become standardized to encompass knowledge of diverse care management in different clinical settings and teach the fundamentals of decision making, team leadership, and quality improvement as essential pillars in every nurse's professional formation. Currently, three different educational pathways to become registered nurses exist: pursuing a bachelor's degree in nursing (BSN), pursuing an associate degree in nursing (ADN), and pursuing a diploma in nursing. The different pathways promote many opportunities for people of different backgrounds and financial statuses to enter the profession but the lack of standardization weakens the unified force of nursing due to differences in clinical education and competencies in areas of public policy, leadership, and systems thinking, all of which are essential for the nursing workforce today.

Increasing the percentage of nurses with a BSN would standardize knowledge and skills necessary to address the changing context of the patient population. The Institute of Medicine, now the National Academy of Medicine (NAM) recommends that the proportion of nurses with baccalaureate degrees be ***Continued on page 2***

Advocating for Patients: Strategies That Work

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A vital aspect in providing optimal quality health care relates to ensuring open communication between not only the patient and the provider, but also between every health professional involved in the patient's care. Numerous techniques have been implemented in healthcare to prevent avoidable misunderstandings, as well as to help empower health professionals to speak up when they are concerned for a patient's safety. Clear and effective communication is essential to navigate the hierarchy in the healthcare system, create a culture of safety, and decrease the patient's risk of suffering an avoidable mistake due to poorly conveyed messages.

To improve communication safety within the hospital and between individual health care professionals, the check-back technique can be implemented. It confirms that both parties understand the order by requiring the receiver to repeat it back to the sender. The two challenge rule is another strategy that works to combat miscommunication between healthcare professionals. If a worker has a concern and believes he or she is not being heard, it is their obligation to address it a second time so that others recognize the concern also.

Another strategy to enhance the culture of safety in hospitals is using **CUS**. This acronym stands for I am **C**oncerned, I am **U**ncomfortable, and this is a **S**afety issue. It brings other co-workers attention to the present concern. Using CUS will quickly draw other healthcare professionals to address the current safety concern and allow for a quick and professional resolution of it, therefore helping promote safe and quality care for patients. This technique gives all healthcare professionals a necessary tool to be able to advocate and speak up for their patients, further advancing a culture of safety in the healthcare system.

Another patient advocacy technique that empowers all individuals involves using critical language such as "I need clarity". By using this statement, it forces healthcare professionals to double check what they are doing before an impending mistake can be made. For example, if a surgeon is about to operate on the wrong arm, any health care professional in the room may advocate for the patient by saying "I need clarity," at which point everyone should stop and review what is being done, bringing the surgeon's awareness to the potential wrong-site surgery, which allows for correction, without causing embarrassment or blame.

Lastly, cross-monitoring has been universally enacted in healthcare to reduce errors related to patient harm. It entails team members providing a safety net by being aware of situations and changing conditions, which allows for preparation and support of colleagues. This helps ensure the best care for patients by preventing patient harm. Implementing effective communication tools and techniques empowers health care professionals to advocate for their patients and improves communication between coworkers. Preventing health care error supports a culture of safety and enhances the well-being of patients.

1. Team*STEPPS* team strategies & tools to enhance performance and patient safety. Retrieved from http://www.ahrq.gov/professionals/education/curriculum-tools/teamstepps/instructor/essentials/pocketguide.html

Error in a Just Culture

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We are taught from the time we are children that punishment follows errors. This culture of "shame and blame" has carried over to healthcare, where even small mistakes can have massive consequences. Consider the following scenario: A physician has just seen a patient and is prescribing medication through the electronic health record. The system is new to the hospital system and the workers are not completely comfortable with using it. The physician does not notice that the system is automatically set to milligrams for the medication instead of the microgram dose he wants to order. A flag on the order comes up at the pharmacy, but it is ignored due to the frequency of medications being wrongly flagged with the new system. The nurse administering the medication toward the end of her shift has a patient load greater than usual and due to her stress and fatigue, does not check that the dose is correct before administering it.

Because she gave the incorrect dose to the patient, the nurse would likely be disciplined in a culture of blame. Legally, this takes care of the problem and is why it is indirectly adopted so widely, but systematically, nothing changes to prevent future errors from this action. Fear of repercussion frequently stops healthcare workers from reporting errors, increasing the likelihood of them happening again. Additionally, an inability to openly discuss errors takes a psychological toll on workers as they strive for perfection or harbor unaddressed guilt[1]. The end result is that patients and healthcare workers are at risk for similar outcomes occurring again.

An alternate way of approaching errors is to implement a just culture in patient settings, where individual and system accountability and safety are balanced. In a just culture, workers report all errors, including those that do not produce an adverse effect, in hopes of producing systematic changes and learning from past mistakes. The following fairness algorithm is used to assess whether or not a worker who erred is deserving of blame: 1) Did they intend harm? 2) Were they impaired? 3) Did they know their action was unsafe? 4) Do they have a history of similar errors? 5) Could two or three of their peers have done the same? Using this algorithm helps to identify situations where individual blame will be ineffective in putting an end to the circumstances that led to the error in the first place[2].

Just culture results in improvement to design principles such as standardization, less reliance on memory, and more effective team functioning[3]. Team*STEPPS* is an evidence-based program developed to prevent errors from occurring. Through communication methods like check-back and standardized hand-offs (SBAR), practitioners can convey information clearly and effectively. Briefing, debriefing, and feedback prevent misunderstandings and clarify facts, and mutual support for one another allows all members of a team to feel that their voice is heard[4]. This and other effective programs can come about only through studying how errors occur, which demands the transition from blame cultures to just cultures in healthcare systems.

1. Frankel, A., Federico, F., Ogrinc, G., & Huber, S. (2016). Responding to adverse events. Retrieved from http://app.ihi.org/lmsspa/#/6cb1c614-884b-43ef-9abd-d90849f183d4/614af4d5-09ed-4c08-b495-59673b0a581a
2. Fink, L., & Garfunkel, S.G. (2016). Introduction to patient safety. Retrieved from http://app.ihi.org/lmsspa/#/6cb1c614-884b-43ef-9abd-d90849f183d4/c67a038c-b021-43c3-b7b8-f74e4ec303f4
3. Federico, F. (2016). Human factors and safety. Retrieved from http://app.ihi.org/lmsspa/#/6cb1c614-884b-43ef-9abd-d90849f183d4/0d1d53a1-1ec4-4065-8250-56247132fb9e
4. Agency for Healthcare Research and Quality. (2014). Team*STEPPS* 2.0 video training tools. Retrieved from https://www.ahrq.gov/teamstepps/instructor/videos/index.html

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be increased to 80 percent by 2020 to increase the number of nurses with competencies in the domains of community and public health, leadership, systems improvement and health policy.[1] New programs to foster this change include seamless education programs for ADNs to become BSNs and online courses with realistic simulations. Nursing curricula should seek to prepare and motivate more students to pursue advanced practice positions and the NAM recommends that the number of nurses with a doctorate degree should double by 2020.[1] Perhaps one of the most effective ways to sculpt a new generation of nurses would be to emphasize the importance of lifelong learning, continuation of education, and expanding the prevalence and content of nurse residency programs. Bridge programs, specifically programs such as the LPN to BSN, ADN to BSN, and ADN to MSN are intended to facilitate academic continuation to higher levels of practice and increase diversity within nursing, strengthening the workforce and patient care outcomes. To further diversify the future of nursing, nursing schools should focus on recruiting and retaining students from different ethnic backgrounds to increase cultural competency and positive patient outcomes in the workforce.

A shortage of nurses with adequate skills can be attributed to high turnover rates, in which nurses are continuously replaced with others, effectively deteriorating the unity and consistency of care. Establishing nurse residency programs in hospitals supports the transition to practice and reduces high turnover rates, allowing nursing graduates to attain the knowledge and skills necessary to deliver exceptional patient care. Most residency programs are supported in hospitals and targeted at acute care, but encouraging these programs to expand into community-based settings to address chronic illness would be beneficial in developing critical competencies in response to the changing face of healthcare and illness. As a force of more than 3 million members, every day nurses work directly with patients and have a profound effect on the quality of care and the functioning of the health care system. Addressing the diversity and context of patients' needs and transcending barriers of traditional roles of nurses can only be accomplished through a transformation of nursing education and emphasis of BSN degrees or higher to accommodate the modern health care system.

1. The Future of Nursing: Focus on Education. 2010. Institute of Medicine of the National Academies. Retrieved November 20, 2019 from: http://nationalacademies.org/hmd/~/media/Files/Report%20Files/2010/The-Future-of-Nursing/Nursing%20Education%202010%20Brief.pdf

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