



# CHARTING NURSING'S FUTURE

REPORTS ON POLICIES THAT CAN TRANSFORM PATIENT CARE

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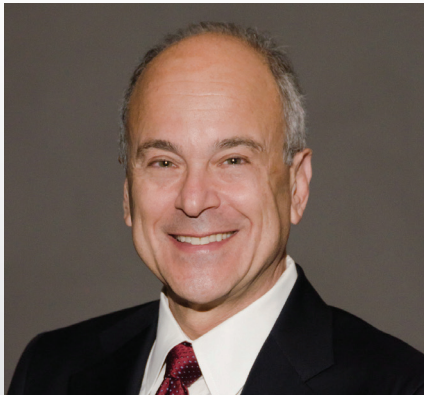
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## Ten Years After *Keeping Patients Safe*: Have Nurses' Work Environments Been Transformed?

A decade has passed since the Institute of Medicine (IOM) published *Keeping Patients Safe: Transforming the Work Environment of Nurses*. The report revealed that, “the typical work environment of nurses is characterized by many serious threats to patient safety.” To counter these threats and reduce health care errors in hospitals and other settings where nurses care for patients, the 2004 report recommended fundamental transformation in the work environment of nurses—that is, changes to how the workforce is deployed, to how work processes are designed, and to the leadership, management, and culture of health care organizations.

Despite notable achievements in improving health care quality since that time, patients remain at risk of serious harm. A 2010 report prepared by the U.S. Department of Health and Human Services (HHS) found that 27 percent of hospitalized Medicare beneficiaries were harmed in some way by the care they received during hospitalization (see table, below). Physician review of these harmful events determined that 44 percent were “clearly” or “likely” preventable. Their cost to the federal government: an estimated \$324 million in October 2008 alone.

This brief revisits some of the IOM report’s recommendations for averting such harm, highlights both progress and persistent gaps in transforming nurses’ work environments, and showcases research, policies, and tools with the potential to advance this transformation.



*“Highly reliable health care organizations demonstrate a culture of safety, a preoccupation with process improvement, and a sustained leadership commitment to the ultimate goal of zero patient harm. Nurses are critical in all these areas and vital to achieving exemplary levels of quality and safety.”*

**–Mark R. Chassin, MD, FACP**  
President and Chief Executive Officer,  
The Joint Commission

**Figure 1.**

### Harms to Medicare Beneficiaries During and Following Hospitalization

Type of Harm*		Result	
<b>Adverse Events</b>	13.5%	Prolonged hospital stay	62%
		Permanent harm	5%
		Life sustaining intervention	23%
		Contributing to death	10%
<i>Examples: severe allergic reaction; pneumonia following surgery</i>			
<b>Temporary harm events</b>	13.5%	Required intervention	100%
		<i>Examples: skin abrasion or bruising and bleeding at intravenous site</i>	

\*All harms caused by medical intervention as opposed to the health condition of a patient.

Data based on a nationally representative sample of 780 Medicare beneficiaries randomly selected from nearly 1 million beneficiaries discharged from hospitals during October 2008.

**Source:** HHS Office of Inspector General. *Adverse Events in Hospitals: National Incidence Among Medicare Beneficiaries*. OEI-06-09-00090. Washington, DC: U.S. Government Printing Office, November 2010.

## Progress in Transforming Nurses' Work Environments

Do hospitals and long-term care facilities deliver their services as safely and reliably as the nuclear power and aviation industries do? Ten years ago the authors of *Keeping Patients Safe* posed this provocative question in their effort to determine whether the environments in which nurses work safeguard or threaten the health of patients. The IOM study determined that most health care organizations cannot be considered high-reliability organizations, that is, high-risk enterprises with low accident rates (see box, below). In fact, the report found evidence of health care management practices that thwart the creation of a culture that values and promotes safety. These practices included:

- ▶ a lack of measurement and feedback to staff who participate in process improvement;
- ▶ an inconsistent commitment by organizations to sustain change over time in the face of adversity; and
- ▶ a lack of consistent involvement in process redesign by frontline staff—including nurses.

These practices contribute to routinely harming many of the people health care organizations are meant to serve and adding avoidable costs to the system (see Figure 1, p. 1).

Since the publication of *Keeping Patients Safe* in 2004, leading public and private

initiatives have laid a foundation for progress in transforming nurses' work environments to improve patient safety. The evidence base describing the impact these environments have on the quality of patient care has grown in size and rigor. Respected organizations have endorsed performance measures that evaluate nurses' contributions to the quality of inpatient care. Hundreds of hospitals have committed to improving nurses' working conditions. And health care organizations that view teamwork and staff engagement as potential remedies to their safety ills have embraced interprofessional collaboration.

Accreditation standards now require health care organizations to establish codes of conduct, and some providers have developed additional ways to promote professional behavior. Finally, legislative efforts to ensure adequate staffing in hospitals and nursing homes have become part of the safety agenda at both the state and federal levels.

Yet safety experts, including Peter J. Pronovost, MD, PhD, FCCM, senior vice president for patient safety and quality, director of the Armstrong Institute for Patient Safety and Quality, Johns Hopkins Medicine, are far from satisfied. "While we have made progress in standardizing practice and reducing some harms such as infections, progress has been too slow, too spotty, and too localized," he says.

The majority of health care organizations do not, in fact, have programs in place

to transform nurses' work environments, although tools exist to allow almost every institution to start on a path to improved quality and safety (see p. 8). This brief examines six areas of progress made over the last decade: creating work environments that foster patient safety (see p. 3), ensuring adequate nurse staffing (see p. 4), combating disruptive behavior (see p. 5), harnessing nurse leadership (see p. 6), and fostering interprofessional collaboration (see p. 6).

### IOM Recommendations: Patient Safeguards in the Work Environment of Nurses

- ▶ governing boards that focus on safety;
- ▶ leadership and evidence-based management structures and processes;
- ▶ effective nursing leadership;
- ▶ safe and adequate staffing;
- ▶ organizational support for ongoing learning and decision support;
- ▶ mechanisms that promote interprofessional collaboration;
- ▶ work design that promotes safety; and
- ▶ organizational culture that continuously strengthens patient safety.

**Source:** Committee on the Work Environment for Nurses and Patient Safety. *Keeping Patients Safe: Transforming the Work Environment of Nurses*. Washington, DC: National Academies Press, 2004.

### Management Practices of High-Reliability Organizations

*Keeping Patients Safe* describes the structure and function of "high-reliability organizations"—enterprises that achieve safety by recognizing that people will inevitably make mistakes and by putting systems in place to reduce the risk of harm when those mistakes occur. These organizations achieve safety by:

- ▶ balancing the tension between production efficiency and reliability (safety);
- ▶ creating and sustaining trust throughout the organization;
- ▶ actively managing the process of change;
- ▶ involving workers in decision-making pertaining to work design and workflow; and
- ▶ using knowledge management practices to establish the organization as a "learning organization."

**Sources:** IOM. *Keeping Patients Safe: Transforming the Work Environment of Nurses*. Washington, DC: National Academies Press, 2004. Chassin MR and Loeb JM. "High-Reliability Health Care: Getting There from Here." *The Milbank Quarterly*, 91(3): 459-490, 2013.



*"Chaotic and inefficient care environments contribute to job dissatisfaction, nursing staff turnover and a diminished institutional*

*capacity to provide high-quality care. If we are truly committed to keeping patients safe, creating and sustaining healthy work environments for nurses is essential."*

**—Linda Burnes Bolton, DrPH, FAAN**  
Vice President for Nursing, Cedars-Sinai Medical Center

## Nurse-Led Initiatives that Improve Safety

In the decade since *Keeping Patients Safe* was published, a number of programs designed by and for nurses spurred the creation of work environments that foster health care quality and patient safety. *Transforming Care at the Bedside (TCAB)*, funded by the Robert Wood Johnson Foundation and developed in collaboration with the Institute for Healthcare Improvement, was among the first and most influential of these. Begun in 2003, *TCAB* sought to improve patient care by empowering frontline nurses to address quality and safety issues on their units. This approach contrasted with traditional top-down improvement efforts and produced measurable results.

A 2011 study examining *TCAB*'s impact on a group of 13 medical-surgical units in 10 hospitals found that *TCAB* largely met its initial goals of improving patient safety and enhancing nurses' job satisfaction and retention. The majority of units studied saw a significant decrease in injury-producing patient falls and 30-day hospital readmission rates. While voluntary nurse turnover remained essentially unchanged, nurse engagement in quality improvement rose, and *TCAB* innovations spread to other hospital units. *TCAB* units also reduced staff overtime, translating to an average net financial gain of \$625,603 per *TCAB* unit over three years.

In collaboration with RWJF, and because of *TCAB*'s impact, AONE began disseminating the program in 2007. The following year, RWJF set the stage for *TCAB*'s continued growth by integrating the program with *Aligning Forces for Quality (AF4Q)*, the Foundation's signature effort to improve the quality of health care and reduce disparities in targeted communities.

In response to continuing demand from hospital nurse leaders for support in transforming nurses' work environments, AONE launched the Center for Care Innovation and Transformation three years later. AONE's Care Innovation and Transformation (CIT) initiative is built on *TCAB*'s basic tenets. It establishes learning communities among hospital units, facilitates knowledge sharing, and makes use of tools and services that support unit-level transformation. Like nurses who were involved in *TCAB*, CIT participants have reported measurable improvements to patient safety and nurses' work environments. These have included:

- ▶ significant reduction in injury-producing falls;
- ▶ decreased incremental (unplanned) overtime with a savings of more than \$1,900 per month;
- ▶ a decrease in nurse turnover from 18 to 3 percent;

- ▶ spread of the CIT process hospital-wide to 47 departments and 3 affiliated hospitals; and
- ▶ an 8-percent increase in nurse time spent at the bedside.

Other leading public agencies, corporations, and philanthropic organizations have made strides in advancing the patient safety agenda (see p. 7). Collectively they have laid the groundwork for transforming nurses' work environments and begun creating a blueprint to guide future action.

### Educational Initiative Targets Nurse Faculty

*Quality and Safety Education for Nurses (QSEN)* is a multiyear project funded by RWJF. *QSEN* workshops have prepared thousands of faculty teaching in graduate and undergraduate programs at nearly 600 nursing schools to integrate quality and safety competencies into nursing school curricula. *QSEN* contributes to the improvement of health care systems, including the work environment, by infusing quality and safety instruction in nursing education at all levels and in clinical as well as academic settings.

**For More Information:**  
Visit <http://qsen.org>.

## The Value of Nurse-Led Innovation



Photo: Copyright 2006, Roger Tully. Used with permission from the Robert Wood Johnson Foundation.

At UPMC Shadyside, a hospital in Pittsburgh, Pa., nurses used to waste precious time locating their patients' medications because there were no rules in place for emptying the pneumatic tube that delivered them. Following the advent of a *TCAB* pilot on a medical cardiology unit in 2004, nurses decided to designate a member of the administrative staff stationed near the delivery site to empty the tube,

place medications in each patient's assigned drawer, and flag the drawer to signify the medications' arrival. This strategy decreased the time RNs spent locating medications from 68 to 17 minutes per day, freeing up time to spend with patients at the bedside. The strategy spread to other units and was also employed in managing chart documents and other items arriving via the pneumatic tube.

## Strategies for Further Transformation: Ensure Adequate Nurse Staffing

In recent years, institutional and state policy-makers have been especially active in pursuing policies aimed at ensuring that the number of nurses on staff is adequate for the delivery of safe patient care. This activity has occurred despite mixed evidence on what constitutes adequate staffing. In 2007, *Charting Nursing's Future #5* offered a detailed look at the controversies surrounding nurse-staffing policy. Since then, a deeper understanding has emerged that staffing adequacy is a function of the composition as well as the size of the nursing workforce, and concerted efforts are now underway to increase the education level of nurses (see *Charting Nursing's Future #21*). Despite this progress, controversy persists regarding the most effective approach to staffing. Some national organizations strongly advocate for fixed ratios while others support upwardly adjustable, unit-specific minimum staffing levels, which account for changes in the intensity of patient care needs and varying levels of RN education and experience. As the debate continues, some states are actively advancing these and other legislative approaches.

### States Address Nurse Staffing

In 2004, the authors of *Keeping Patients Safe* stopped short of offering a formula for achieving safe staffing, but stated unequivocally that the “number of nursing staff available to provide in-patient nursing care is linked to patient safety.” Since then, the state of California has provided a living laboratory for evaluating one approach to ensuring adequate nurse staffing: the use of ratios.

In 1999, California became the first and only state to set a limit on the number of patients a nurse could care for in acute care hospitals: five patients to every RN or licensed vocational nurse on general medical-surgical units, and fewer patients to each licensed nurse on some specialty units. A 2010 synthesis of research by Donaldson and Shapiro, which examined the impact of the law, suggests that while the mandate

has effectively reduced the number of patients assigned to each nurse, desired improvements in cost, quality, and safety have not been consistently or universally achieved.

Nevertheless, Donaldson and Shapiro posit that reducing the number of patients assigned to each nurse may offer those at risk for complications some protective benefit. The researchers based their supposition on findings from a 2009 study by Antwi et al. It found that during the period that the staffing mandate was implemented, patients' conditions increased in severity—a situation that would normally increase the risk of adverse events. While this finding is promising, the lack of clear and consistent positive effects from California's mandate reinforces the argument that nurse-staffing legislation is not a panacea for improving quality and safety.

Some other jurisdictions have passed nurse staffing legislation that excludes ratios. In March 2008, the state of Washington passed the Safe Nurse Staffing Act, which directed hospitals to establish committees to oversee nurse staffing. The following year Minnesota passed a provision requiring health care facilities to consider staffing levels and their impact on adverse events when identifying and eliminating the sources of such events. More recently, the Illinois Hospital Licensing Act was amended to require hospitals to publically disclose their nurse staffing plans beginning in January 2012.

While there has been considerably more state movement toward than away from staffing legislation since 2004, two jurisdictions have stopped seeking enactment of staffing ratios. Maine pointed to the lack of reliable scientific evidence linking mandated RN staffing ratios with improvements in quality and safety, and the District of Columbia cited the nursing shortage in explaining its actions.

### Debate Lingers on Nurse Staffing Standards in Nursing Homes

In 2004, *Keeping Patients Safe* assumed a stronger stance on establishing staffing standards in nursing homes because of the relative strength of the evidence linking

staffing to patient outcomes in long-term care facilities. Specifically, the IOM report recommended that the Department of Health and Human Services (HHS) update its 1990 staffing regulations in keeping with a 2001 Center for Medicare & Medicaid Services (CMS) study, which found persistent and significant associations between staffing and risk-adjusted rates of adverse events. In response, HHS reviewed the 1990 staffing regulations, but ultimately the department opted not to revise its minimum staffing levels. Instead HHS strengthened the accuracy of its nurse staffing data by making adjustments for resident acuity and created mechanisms for auditing, transmitting, and publicly disclosing these data. The 1990 regulations remain in place today despite research demonstrating the benefits of increased nurse staffing in nursing homes (see box, below).

### Evidence of the Benefits of Increased Nurse Staffing in Nursing Homes

- ▶ In 2008, a study by Susan Horn found an absolute savings of nearly \$3,200 per resident annually when RN direct care time was increased from 10 to 40 minutes per day. The cost of additional nurse wages was offset by the savings accrued from reductions in pressure ulcers and urinary tract infections.
- ▶ In 2008, a study by Frederic H. Decker of the National Center for Health Statistics found that higher RN staffing levels reduced hospitalizations for residents who had been admitted from hospitals and remained in the nursing home for more than 30 days.
- ▶ In 2009, Kim et al. found a decrease in total regulatory and other serious deficiencies (unmet health and safety requirements) as the ratio of RNs to licensed vocational nurses increased in nursing homes.

## Strategies for Further Transformation: Curb Unprofessional and Disruptive Behavior

While professional discourtesy, intimidation, and bullying exist in many workplaces, the consequences of unprofessional behavior can be monumental when patients' lives are at stake. A 2010 study of nurses working in critical care and surgical settings, *The Silent Treatment: Why Safety Tools and Checklists Aren't Enough to Save Lives* (Maxfield et al.), found that even when safety tools indicated a patient care problem, fewer than one-third of nurses felt comfortable speaking up and were able to get coworkers to listen to their concerns. In addition to undermining a culture of safety, verbal abuse and other forms of unprofessional or disruptive behavior also negatively affect clinicians' working relationships, the efficient flow of information and communication, and employers' ability to retain nurses on staff.

A separate study by Brewer, Kovner, Obeidat, and Budin (2013) looked at the impact of verbal abuse on early career RNs and found that their perceptions of the quality of their work environment declined as exposure to verbal abuse increased and that both factors correlated with the nurses' intent to seek work elsewhere. Interestingly, an increase in verbal abuse from physicians was associated with an increase in verbal abuse from nursing colleagues as well.

Researchers at The Johns Hopkins Hospital and The Johns Hopkins University School of Nursing are studying disruptive behavior and the factors that trigger its occurrence.

In a recent survey of frontline nurses and physicians, 84 percent of more than 1,500 respondents reported personally experiencing disruptive behavior within the past year, and more than one-quarter experienced it daily or weekly. Disruptive behavior within disciplines (i.e., nurse to nurse or physician to physician) was experienced more frequently than disruptive behavior between disciplines (i.e., nurses and physicians), and the most common triggering events were organizational factors, most of which also contribute to the quality of nurses' work environments. These included:

- ▶ pressure from high patient counts;
- ▶ elevated numbers of admissions, transfers, or discharges;
- ▶ complexity of patient movement and flow among units;
- ▶ environmental overload including excessive noise and lack of space; and
- ▶ chronic unresolved system issues such as missing medications and a lack of equipment and supplies.

The study also documented actual harm to patients and respondents' intention to leave the organization as a result of disruptive behaviors.

Hopkins has a code of conduct and a system for reporting disruptive behaviors, but survey respondents revealed that they did not use the hospital's formal channels to report these behaviors. Deborah Dang, PhD, RN, principal investigator, and Jo Walrath, PhD, RN, co-investigator of the study, concluded that

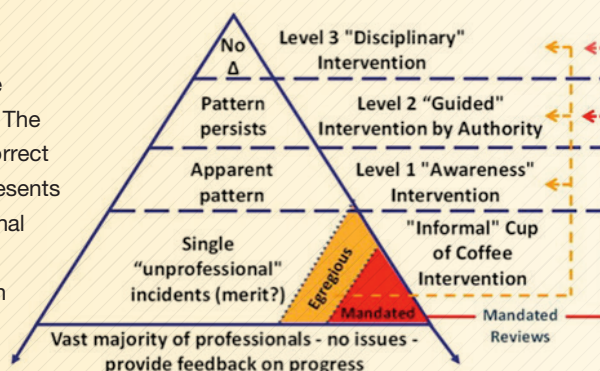
Hopkins must continue to make it safe for staff to speak up when they have a concern and set expectations for the organization's leaders and staff to model the core values of respect and collegiality. As Walrath explains, "Clearly, interprofessional education is part of the answer, but we believe that whatever is done to address this problem, it will take multiple interventions, a commitment of hospital leadership, and engagement of the staff at the unit level."

### The Joint Commission: A Lever for Change

Defining and communicating what constitutes professional behavior is a crucial first step in holding leadership accountable for developing a culture of safety. The Joint Commission (see p. 7) took a bold stand on the subject when it issued a new Leadership standard in 2009 that requires leaders to develop a code of conduct defining behaviors that undermine safety and a process for managing such behaviors. These expectations should facilitate change, yet nurses and physicians report that they view their institutions' policies on disruptive behavior as being less than effective. In light of these findings, the Commission's published guidance (see p. 8) may prove critically important to decreasing behaviors that undermine a culture of safety.

### The Value of Professionalism

Vanderbilt University Medical Center trains selected peer colleagues to promote professionalism and equips them with an escalating "pyramid" of interventions. The pyramid's design facilitates health professionals' ability to recognize and self-correct behavior that undermines safety, quality and reliability. The pyramid's base represents non-punitive collegial meetings in response to isolated incidents of unprofessional behavior. If the pattern continues, interventions include ongoing monitoring and accountability. According to Dr. Gerald Hickson, Vanderbilt's approach has been effective at addressing and reducing behaviors that undermine a culture of safety, saving the organization between \$5.5 and \$8 million annually, not including savings from an 80-percent reduction in malpractice costs.



Adapted from Hickson, Pichert, Webb, Gabbe. Acad Med. 2007. Used with permission.

## Strategies for Further Transformation: Harness Nurse Leadership

The authors of *Keeping Patients Safe* examined changes in the health care marketplace that occurred during the 1980s and '90s and concluded that clinical nursing leadership was "at risk." The report cited interview and survey data indicating that the expanded responsibilities of senior nurse executives and nurse managers jeopardized their ability to provide adequate clinical leadership to frontline nurses providing direct patient care. In response to these findings, the report recommended increasing clinical nursing leadership at the most senior levels of management in order to facilitate trust, increase nurses' participation in work-design and workflow decision-making, and support knowledge acquisition by nursing staff. Less than a decade later, this position was reiterated in the IOM's report, *The Future of Nursing: Leading Change, Advancing Health*.

New evidence now reveals the tangible benefits of such leadership. A 2013 systematic review of the academic literature exploring the relationship between nurse leadership and patient outcomes found that transformational nursing leadership is associated with higher rates of patient satisfaction and lower rates of select adverse events such as patient mortality, medication errors, and hospital-acquired infections. Although stronger research studies are needed to explain these associations, this synthesis as well as examples from the field suggest that harnessing nurse leadership can improve quality and safety in inpatient settings.

### Championing Quality and Safety from a Seat on the Board

In 2004, Indiana University Health (IUH) appointed Angela Barron McBride, PhD, RN, FAAN, to its board of directors. The former dean of Indiana University's School of Nursing has been instrumental in making sure the IUH board remains focused on implementing the academic health center's quality and safety plan. "Quality and safety are systemic issues that cannot be improved by individual clinicians alone," says McBride. "Working with the IUH board, I've been able to bring my perspective as a nurse to systems level initiatives that are improving patient care."

According to the American Hospital Association, nurses make up only 6 percent of voting members on hospital boards. Lawrence D. Prybil, PhD, LFACHE, Norton Professor in Healthcare Leadership and associate dean in the College of Public Health at the University of Kentucky, has studied nurses' participation in health care governance. He attributes their poor representation to a lack of awareness among board members of nurses' enormous

influence over the quality of patient care, and he faults the gender bias that results in the underrepresentation of women on corporate boards generally. Nevertheless, he foresees change on the horizon.

"A quarter of a century ago, we crossed the bridge to having physicians on hospital and health system boards," says Prybil. "We're now beginning to cross the bridge to include the nursing perspective, expertise, insights, and knowledge of patient care."



*"Many leaders on health system boards lack sufficient clinical knowledge and know little about measuring quality and safety. Given nurses' expertise in these areas, boards would do well to enlist their leadership."*

**—Lawrence D. Prybil, PhD, LFACHE**

Norton Professor in Healthcare Leadership and Associate Dean,  
College of Public Health, University of Kentucky

## Foster Interprofessional Collaboration

When *Keeping Patients Safe* recommended interprofessional collaboration as a means to improve safety, the idea of fostering collaboration on the hospital floor was still foreign to most health professionals. Interprofessional collaboration is still far from universal, but during the past decade, persistently high rates of medical errors and their staggering costs have generated significant interest in the idea of providing care collaboratively, often in teams. In 2011 *Charting Nursing's Future* #17 described this trend and reported that, "a consensus has emerged among those in the vanguard that ... safety and quality goals can best be met by replacing conventional siloed care delivery with a collaborative, coordinated approach that capitalizes on the unique expertise of each profession."

While the 2011 brief showcased more than a dozen models of interprofessional practice and education and examined policies that had fostered such initiatives, achieving this vision remains a work in progress. The first studies demonstrating a positive impact of interprofessional collaboration on patient care are encouraging. For example, a study by researchers at the University of Pennsylvania

and the University of Pittsburgh found that daily rounds by a multidisciplinary ICU team reduced by 16 percent the risk that critically ill patients would die within 30 days. The 2010 study examined admissions at 112 Pennsylvania hospitals over a two-year period.

Proponents of interprofessional collaboration are seeking to answer many of the same questions that have been raised about nurses' work environments and their impact on patient safety. How do health professionals communicate with one another? Do they understand and respect one another's roles? Are processes in place to facilitate the smooth delivery of patient care by teams of providers? Do all members of the team feel empowered to speak up to prevent and mitigate adverse events?

To encourage the delivery of collaborative care, some hospitals have begun offering their health care practitioners interprofessional team training (see p. 8).

### For More Information:

See *Charting Nursing's Future* #17 and visit the National Center for Interprofessional Practice and Education, a Robert Wood Johnson Foundation grantee, at <http://nexusipe.org>.

## Leaders in Patient Safety and Workplace Improvement

Public agencies and private organizations dedicated to health care quality and nursing practice have made major strides in advancing the patient safety agenda and laid the groundwork for transforming nurses' work environments. Collectively, their contributions have impacted thousands of hospitals and addressed many of the challenges identified in *Keeping Patients Safe*. Experts anticipate that these groups will remain influential and that the pace at which their programs are adopted will accelerate.

### Government Sector

**Agency for Healthcare Research and Quality (AHRQ).** This division of the U.S. Department of Health and Human Services (HHS) is credited with identifying the need to study nurses' work environments in the context of patient safety. AHRQ contracted with the IOM to conduct the study that produced *Keeping Patients Safe* and funded several other studies that examined ways in which nurses' workload and working conditions can result in harm to patients' health. This research provided critical baseline data for charting future progress.

### Professional Associations

**American Nurses Association (ANA).** This professional association has made enduring contributions to quality, safety, and patient care. Chief among these is the ANA's National Database of Nursing Quality Indicators® (NDNQI), the only national system for measuring the quality of nursing care that allows hospitals to chart the performance of individual units and compare their performance against regional, state, and national norms. In 2006, a 31-item survey measuring the adequacy of the practice environment was added to NDNQI. Hospitals use the information gathered through NDNQI to adjust workforce variables such as nurse staffing, skill mix, nurses' participation in leadership, and nurse-physician collaboration as they strive to reduce risks to patient health.

**American Organization of Nurse Executives (AONE).** This subsidiary of the American Hospital Association has been a leader in disseminating programs and tools aimed at transforming nurses' work environments. In 2010, AONE created the Center for Care Innovation and Transformation (see p. 3). As part of a coalition of nursing organizations, AONE also developed the Workplace Environment Assessment Tool, a survey that captures and compares nurses' and hospital leaders' views about the work environment. This tool helps hospitals better orient new nurses and set targets for workplace improvement.

### Public Service Sector

**National Quality Forum (NQF).** This national not-for-profit brings together a wide range of stakeholders to create consensus on standards for measuring the quality of health care delivery. One of NQF's primary contributions to the improvement of patient safety has been its endorsement of National Voluntary Consensus Standards for Nursing-Sensitive Care. These standards have been instrumental in fostering a greater understanding of the relationship between nursing, the care environment, and patient safety.

### Credentialing Organizations

**The Joint Commission.** This independent, not-for-profit accreditation and certification organization seeks to continuously improve health care by evaluating health care organizations on important patient care and organization functions, including nursing,

that are essential to providing safe, high-quality care. The Joint Commission evaluates and accredits more than 20,000 health care organizations and programs nationwide, certifies more than 2,000 disease-specific care programs, and provides health care staffing services certification for more than 750 staffing offices.

**American Nurses Credentialing Center (ANCC).** This ANA subsidiary established and operates the Magnet Recognition Program®, which recognizes health care organizations that attract and retain top nursing talent. In evaluating organizations for Magnet Recognition, the program uses a set of criteria that correspond to characteristics of nurses' work environment—first described in *Keeping Patients Safe*—that safeguard patient health.



*"Improving nurses' work environments will reduce preventable harm, reduce costs, and restore joy in work. With the right leadership, all of this can improve,*

*right now, for patients receiving care tomorrow."*

**—Peter J. Pronovost, MD, PhD, FCCM**  
Sr. Vice President for Patient Safety and Quality, Director of the Armstrong Institute for Patient Safety and Quality, Johns Hopkins Medicine

### RWJF Future of Nursing Report

In 2008, the Foundation and the IOM jointly undertook a study to examine the capacity of the nursing profession to fulfill the promise of health care reform and meet the nation's expanding demand for care. The resulting report, *The Future of Nursing: Leading Change, Advancing Health*, recognizes the importance of nurses and the nursing work environment in promoting care that is safe, effective, patient-centered, timely, efficient, and equitable. Currently the Foundation is supporting federal and state-level efforts throughout the nation to implement the report's recommendations through the Future of Nursing: *Campaign for Action*.

**For More Information:** Visit <http://www.iom.edu/Reports/2010/The-Future-of-Nursing-Leading-Change-Advancing-Health.aspx> for the IOM report.

## An Emerging Blueprint for Change

Over the last decade, considerable investments have been made in transforming nurses' work environments and safeguarding patient health. Providers, policy-makers, and educators can build on these investments using the strategies presented in this brief:

- ▶ monitoring nurse staffing and ensuring that all health care settings are adequately staffed with appropriately educated, licensed, and certified personnel;
- ▶ creating institutional cultures that foster professionalism and curb disruptions;
- ▶ harnessing nurse leadership at all levels of administration and governance; and
- ▶ educating the current and future workforce to work in teams and communicate better across the health professions.

Stakeholders can also follow through on the recommendations in *Keeping Patients Safe* using a wide range of 21st century tools (see table, below). These can serve as powerful levers for further advancement.

Taken together, these diverse instruments provide a substantive but partial blueprint for change. While the focus on improving nurses' work environments must remain integral to efforts to safeguard patient health, achieving the ultimate goal of zero patient harm will require engaging all stakeholders in the design and improvement of care delivery. To date, patients and their families have been largely excluded from this conversation, but leading safety organizations agree that moving forward, consumers will have a major role to play in improving health and preventing harm.



*"Requiring safe levels of nurse staffing in hospitals is an essential step in protecting patients from harm, but those levels may vary.*

*The characteristics of both patients and hospital units need to be considered in determining what constitutes safe staffing. Only when staff nurses themselves are directly involved in making that determination will our hospitals achieve safer, higher-quality care."*

–Representative David Joyce (R-OH)  
Co-Chair of House of Representatives Nursing Caucus for the 113th Congress

TOOLS FOR POLICY-MAKERS	TOOLS FOR HEALTH CARE ORGANIZATIONS	
<p><b>Nurse Staffing Regulation</b> Future nurse staffing legislation can benefit from the attempts of more than a dozen states that have preceded them in passing legislation mandating staffing ratios or other requirements. For a summary of state legislative approaches, visit <a href="http://www.nursingworld.org">www.nursingworld.org</a>.</p> <p><b>Public Reporting</b> State and federal governments can inform consumers and stimulate change by publicly reporting health facilities' nurse staffing and creating incentives for other entities to report these data. Massachusetts and Maine offer examples. Visit <a href="http://www.patientcarelink.org">www.patientcarelink.org</a> and <a href="http://www.mqf-online.com">www.mqf-online.com</a>.</p>	<p><b>Magnet Recognition Program®</b> Health care facilities can improve their nursing work environments and increase safety by working toward Magnet recognition. Visit <a href="http://www.nursecredentialing.org/magnet">http://www.nursecredentialing.org/magnet</a>.</p> <p><b>Performance Measures</b> Tracking performance measures can promote institutional accountability for quality improvement by making visible nurses' contributions to safe, high-quality care and helping organizations assess and improve the work environment. Find NQF-endorsed™ nursing-sensitive outcome measures developed by The Joint Commission in collaboration with the ANA at <a href="http://www.jointcommission.org/library_of_other_measures.aspx">http://www.jointcommission.org/library_of_other_measures.aspx</a>.</p> <p><b>Codes of Conduct and Incident Reporting Systems</b> Formal policies governing professional behavior can help institutions clarify that disruptive behavior will not be tolerated in the workplace and create mechanisms for reporting such behavior. See The Joint Commission's Sentinel Event Alert at <a href="http://www.jointcommission.org/assets/1/18/SEA_40.PDF">http://www.jointcommission.org/assets/1/18/SEA_40.PDF</a>.</p>	<p><b>Interprofessional Training</b> Evidence-based training programs such as TeamSTEPPS® (developed by AHRQ and the U.S. Department of Defense) can help practitioners, clinicians, and educators improve communication and teamwork. Visit <a href="http://teamstepps.ahrq.gov">http://teamstepps.ahrq.gov</a>.</p> <p><b>Environmental Assessment Tools</b> Health care organizations can assess, track, and improve patient safety and the nursing work environment using AONE's Workplace Environment Assessment Tool and AHRQ's Patient Safety Culture Assessment Tools. Visit <a href="http://www.aone.org">www.aone.org</a> and <a href="http://www.ahrq.gov">www.ahrq.gov</a>.</p>
TOOLS FOR CONSUMERS	TOOLS FOR EDUCATORS	
<p>Leading organizations including AHRQ, Consumers Advancing Patient Safety, and the National Patient Safety Foundation provide consumers with educational resources to advocate for safer, higher-quality health care. Visit <a href="http://ahrq.gov">http://ahrq.gov</a>, <a href="http://npsf.org">http://npsf.org</a>, and <a href="http://consumersadvancingpatientsafety.org">http://consumersadvancingpatientsafety.org</a>.</p>	<p>The <i>Quality and Safety Education for Nurses (QSEN)</i> project has developed a rich repository of free, web-based resources that educators and schools of nursing can employ to integrate quality and safety competencies into their curricula. Visit the QSEN Institute at <a href="http://qsen.org">http://qsen.org</a>.</p>	

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