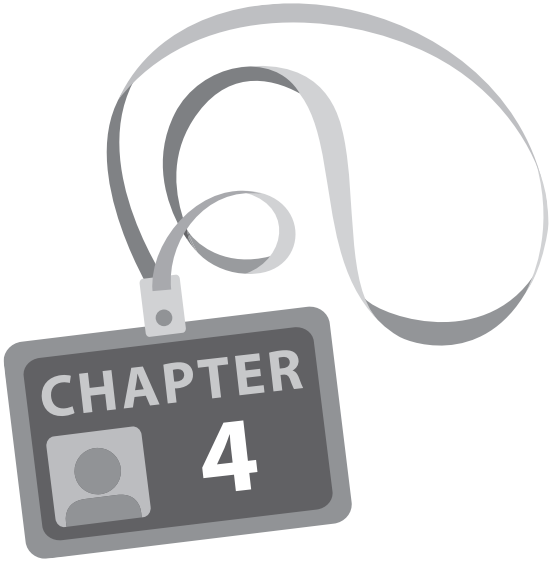
"Only three things happen naturally in organizations: friction, confusion, and underperformance. Everything else requires leadership."

–Peter Drucker



Day-to-Day Operations

It has been said, "managing makes a manager." However, it does help to have information about the nurse manager's day-to-day duties and responsibilities before being faced with carrying them out.

Supporting effective day-to-day operations is the core of the nurse manager's activities. Staffing and scheduling personnel, delivering patient care through an appropriate nursing care delivery model, and meetings (e.g., leading team meetings, attending organizational planning meetings, supporting patient care conferences) are all activities vital to the day-to-day functioning of a patient care unit or area. Information about these subjects, and other topics related to the day-to-day operations of a nursing unit or area, are discussed in this chapter.

Intertwined with these subjects are strategies for their implementation, as well as the quest for cost-effective, quality patient outcomes, with a focus on the patient experience. The nurse manager needs to consider these things while working to promote the professionalism, satisfaction, and engagement of the patient care team.

Quality: The Foundation for Effective Daily Management of Operations

The following classic statement by Hughes (2008, pp. 1–25) summarizes healthcare's many complex and moving parts:

> "Everything about health care is complex. There are complex care processes, complex health care technologies, complex patient needs and responses to therapeutic interventions, and complex organizations. There are tremendous opportunities and challenges in improving the quality and safety of health care, but the majority require purposeful redesign of health care organizations and processes. Organizations that are committed to high-quality and safe care will not place nurses at the 'sharp end' of care, but will focus on system improvements. Recognizing the complexity of care and how several factors combine at a specific time and result in errors and adverse events, organizations, leaders, and clinicians will dedicate themselves to using data and evidence and to continuously improve the quality and safety of care, even when there are complex challenges."

Quality is very difficult to define, especially in healthcare. However, for the new nurse manager, it is important to understand and integrate quality management and elements of measurement, assessment, and improvement into daily routine. It is also important to understand how each area's performance is aggregated into a total organizational view of quality for internal and external customers. The Institute of Medicine (now the National Academy of Medicine) defines quality as, "The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge" (IOM, 2001, paragraph 3). Quality in healthcare has grown to include the documentation of those structures, processes, and outcomes necessary to replicate quality of care. Quality of care is predicated on positive outcomes, the customer experience, best practices, and cost efficiency.

The IOM Quality Chasm report (2001) identified six specific aims or goals with regard to care: It should be 1) safe, 2) effective, 3) patient-centered, 4) timely, 5) efficient, and 6) equitable. Each healthcare system has the opportunity to develop its own philosophy of patient care delivery, based on its mission statement, values, and the accepted standards of practice for medical, nursing, and other healthcare providers. An effective continuous quality improvement (CQI) program involves the integration of these goals into planning, delivery, evaluation, and revision of processes, all the while measuring outcomes against established benchmarks.

When thinking of quality it is important to look at the big picture. Try to view your area or unit as a stranger would. This activity can help you see the big picture and consider the seemingly simple fundamentals that can make a difference in quality and performance improvement. Questions for consideration might include: "Do patients get admitted in a timely fashion?" "Are the patient rounds used as a time to update and clarify the care plan?" "Are family members and other lay caregivers valued for their input and thoughts?" and "Are adverse events identified in a timely fashion and is a root cause analysis performed expediently while times and event trajectories are remembered accurately?"

If you objectively look at your team and their communications, what are the answers to these questions: "Do you view them generally as compassionate and kind?" "Does the team pitch in and help one another as needed?" "What is the tone and greeting when the unit or area phone is answered?" and more.

Effective managers should never be satisfied with the status quo, especially if there are methods to improve the products or services. Healthcare managers maintain the same clinical practice or administrative operations because they fear change will not survive. Change is synonymous with healthcare and its delivery. Administrative and clinical functioning of a patient care department or area should be reviewed continuously for appropriateness and efficiency, with all team members involved in reviewing what is done, why it is done, and whether it is done correctly the first time. Managers must also think strategically and plan for the inevitability of change. Continuing education seminars, networking, and literature review of pertinent subject matter are important for a manager to both maintain a general view of the healthcare marketplace and to enhance the knowledge base to plan for the future. The sidebar outlines 10 items help achieve and improve quality.

10 ITEMS TO CONSIDER FOR IMPROVING QUALITY

- What does "safe" care look like in our department or area?
- What are three or more safety challenges that can be identified?
- How is "patient-centered care" defined and delivered on our unit and at our organization? What does patient-centered care "look like"?
- What are the numbers or metrics that are available to the nurse manager to gauge the safety and quality of care delivered on a given unit or area?
- What can the nurse leader and team do to improve the patient experience?
- How does the staffing model and schedule support the provision of effective and safe patient-centered care that leads to quality care?
- Does the organization seek credentialed and certified expert clinicians to oversee or case manage care for certain patient populations as a way to improve quality? Some examples include wound, ostomy, and continence nurses; hospice and palliative care certification; and other clinical specialists.
- Experience supports that when there is effective communication and coordination, it leads to a safer environment. What do you do in your area to facilitate communication and teamwork?
- Consider volunteering for an area-based or system-wide safety committee.
- Identify three safety-related articles from peer-reviewed journals that have relevance to your area or organization. Read them and choose them as a topic for a "journal club" with your team members.

Nursing Care Models

New nurse managers need to understand the various types of nursing care models, the strengths and weaknesses of each, and the models' unique value in the setting in which the nurse manager works. Each healthcare setting has the ability to generate clinical practice standards or protocols based on acceptable medical, nursing, or other healthcare-related research data and standards of care. The Agency for Healthcare Research and Quality (AHRQ), a unit of the Department of Health and Human Services (DHHS), has developed a number of evidence-based practice guidelines for various health conditions that have gained acceptance as the core foundation for development of specific practice parameters. Managed care

organizations, as well as professional healthcare organizations, are accepting the validity of such practice standards, which, it is hoped, can decrease the legal liability of utilizing practice standards, once they are widely recognized and accepted by appropriate professional groups.

The AHRQ defines the following four nursing care delivery models (Seago, n.d.):

- **Patient Focused Care:** A model popularized in the 1990s that used RNs as care managers and unlicensed assistive personnel (UAP) in expanded roles such as drawing blood, performing EKGs, and performing certain assessment activities.
- **Primary or Total Care Nursing:** A model that generally uses an all-RN staff to provide all direct care and allows the RN to care for the same patient throughout the patient's stay; UAPs are not used and unlicensed staff do not provide patient care.
- **Team or Functional Nursing Care:** A model using the RN as a team leader and LVNs/UAPs to perform activities such as bathing, feeding, and other duties common to nurse aides and orderlies; it can also divide the work by function such as "medication nurse" or "treatment nurse."
- **Magnet Hospital Environment/Shared Governance:** Characterized as "good places for nurses to work" and includes a high degree of RN autonomy, MD-RN collaboration, and RN control of practice; allows for shared decision-making by RNs and managers.

NOTE

Different organizations have different names and models for their nursing care delivery. Some are hybrids of more than one model.

One role of the new nurse manager is to analyze the current nursing care model for quality. The following questions might be asked:

- Are positive patient outcomes being achieved in a timely, cost-effective manner?
- Are patients and families satisfied with care? (This is known as the *care experience*.)
- Are physicians, referral sources, and other health team members satisfied with the care?
- Would you want your loved one to be cared for there?

Accreditation standards do not specifically dictate which type of nursing care model an organization should adopt, but instead focus on care planning and coordination, safety, assessment, skills of the clinician matching the needs of the patient, and other facets of care delivery.

Practice Standards and Protocols

As outcomes management becomes more integrated into daily operations of all healthcare settings, the need for reliable and valid data is essential. In order for such metrics to be reliable and valid, there needs to be uniformity in how the data are collected and what criteria are utilized in collecting the specific data. In healthcare, it is important to keep a focus on the patient as a person (hence person-centered care) and never just as one element of such metrics. However, in order to analyze outcomes and how they were achieved, as well as to try to quantify the cost of care in terms of monetary values, such core standardization has to occur.

In the process of developing clinical practice guidelines (pathways) and/or protocols, planning teams need to be aware of the current scopes of practice of all licensed/credentialed team members. However, as in all human-related endeavors, flexibility and the ability to apply appropriate medical, nursing, or other clinical judgment into practice standards or protocols are needed. This is also true in the development and implementation of a prescribed plan of care based upon diagnoses and patient acuity levels. It is important to note that sound clinical judgment does not take the place of protocols as the healthcare industry moves toward standardization of care and care processes.

The manager's role is one of support and facilitation, ensuring that proper resources are available to her/his team. Although it takes time to change philosophy, the result is a team that has control over their practice, that practices in a professional manner, and that is more fulfilled and satisfied (which results in employee retention).

Patient Classification Systems

Many patient classification systems are in use across the country. Some were developed specifically for a particular institution, and others were purchased from vendors. Most organizations classify patients daily, and most systems are computerized rather than manual.

Every nurse manager should become thoroughly familiar with the organization's classification system. Usually a person in the organization who assisted with its development and implementation manages it. This is the person to seek out to explain the nuances of the system.

A comprehensive staffing system may comprise a patient classification system or acuity system, a master staffing plan, a scheduling plan, a position control plan, a budget, and/or a number of reports that provide feedback to the manager on these components.

One classic patient classification definition is the "categorization or grouping of patients according to an assessment of their nursing care requirements over a specified period of time" (Perry, 1990, p. 36). It is seen as an objective and structured process to use in determining and allocating staff for patient care. In other words, patients are classified based on the projected number of nursing hours required to provide care. It can also measure productivity and help achieve compliance with accreditation standards. With increasing concerns about scarce resources, cost, and efficiency, patient classification systems can assist with appropriate allocation of resources to effectively meet patient needs and provide justification as necessary for decisions to be made.

The patient classification process generally has two parts: (1) the actual classification procedure (using a tool), and (2) the quantification of hours needed for the nursing care or staffing standards determined for each care category. In other words, for each category of care needed, from those patients needing the least amounts of nursing care to those requiring the most (the acuity level), an average number of nursing care hours is determined. Usually the tools are transferrable among organizations/facilities with similar groups of patients, but the staffing standards are not for a number of reasons. This can include variations such as the strength of support services, environmental factors such as unit or area layout, differences in philosophy, differences in care and medical treatment, and levels and experience of the nursing team. Work-sampling studies measuring indirect and direct care time for the estimation of procedures through trial and error can be performed to establish or support staffing standards.

Two final points must be made concerning patient classification. First, the manager should understand that a high activity level in the unit or area and the acuity level of patients are not necessarily one and the same. Other causes exist that influence activity levels besides higher acuity levels, including factors such as experience and competency of the team members and presence and quality of support

services at the unit level. Second, patient classification data are used as *supports* for decision-making. They never take the place of nurse manager judgment, nor should they ever be taken as facts not to be questioned. See Manager's Tip 4.1 for questions to ask about classification systems.

MANAGER'S TIP 4.1

6 Questions to Ask About Classification Systems

- **Is the patient classification tool based on prototype evaluation or on factor-analysis evaluation?** *Prototypes are broad descriptions of three or four levels, and the patient is compared to the levels and placed in the one that most closely matches their description. Factor analysis is based on a list of critical indicators that, when summed up, indicate a patient category.*
- **What is the process by which the tool is used by the nursing team members?** *It is essential to know each and every step. As issues arise, an awareness of where things can go wrong is helpful in solving problems with the system.*
- **How is the system maintained and monitored? What is the role of the manager?** *You need to know what orientation and ongoing educational programs for team members are available as relates to the system. Reliability checks are usually built into the system. Reliability means consistency between raters. Achieving agreement of at least 90% is generally considered acceptable. Validity monitoring refers to whether the system actually measures what it is supposed to measure. Sometimes surveys of the staff are done or actual time-motion studies are conducted to reaffirm the system.*
- **How are data generated by the system interpreted?** *What should be done with data once they are interpreted? Obviously the manager must understand what the data mean and then how they can be used as aids to staff the unit. Most systems compile and report an acuity number that is the sum of all patients' levels. They then predict the numbers of team members needed on the following shifts.*
- **How exactly is patient classification used in the specific organization?** *Only for staffing on a daily basis? For the annual budget? For productivity? For assignments? For placement of patients on units? For determining costs of patient services?*
- **What are the current challenges with the system?** *The nurse manager should also ask this question of the team members. Sometimes there are problems with "acuity creep," or gradually rising acuity levels. It is usually a managerial responsibility to identify and work at resolving problems related to the system.*

NOTE

Despite millions of dollars expended to find the perfect system, no such thing exists. It is important to keep that in mind.

Scheduling and Staffing

Staffing levels and scheduling considerations impact nurse retention, so the new manager should be aware of scheduling and staffing practices and options. As important as making sure that team members are scheduled and shifts or patient loads covered, it is also a managerial responsibility to assign patients to team members based on a number of factors. This includes assessed patient needs, the patient's acuity levels, and the abilities and competencies of the team members. Many hospitals and other types of healthcare settings have developed "cross-training" programs that assist in maintaining a stable staffing pool to assist with flexibility and "depth" for coverage. Emergency department and critical care staff may be cross-trained, as may neonatal, labor and delivery, and pediatric nurses. With the emergence of more outpatient or ambulatory care areas, many nurses are cross-trained as "procedure" nurses to work in cardiac catheterization laboratories or radiology departments for specialized angiography services. The core of a cross-training program lies in the regular education and testing of team members' competencies to assess their abilities to work in those areas, especially those areas that they frequent less than their primary area(s) for assignment. Ongoing competency assessment and validation efforts (or processes) are key factors in quality and staffing/scheduling.

Scheduling Patterns and Options

Various types of scheduling practices and options have been developed over and above the traditional 8-hour-a-day, 5-day-a-week schedule. Several of the most prevalent patterns are noted in Table 4.1.

TABLE 4.1 FIVE TYPES OF SCHEDULING PATTERNS

Patterns	Comments
8-hour/5-day week	Generally allows for a 30-minute meal break and a 30-minute overlap time if used for 24 hours.
10-hour/4-day week	Provides an opportunity for longer overlaps during activity times, meetings, or educational sessions. Allows the team member an extra day off each week.
10-hour/7-day week	Team member works 7 days on and 7 days off. Provides for better continuity and periods of time off, but end-of-week fatigue is a consideration.
Weekend option	Team member works only on weekends and either works 2 days with 12-hour shifts and is paid for 36 hours, or 2 nights and is paid for 40 hours. There can be variations in this model.
12-hour/3-day week	Provides for better continuity over the course of the shift but not over the week. Allows a team member 4 days off during week.

Almost every conceivable combination of shifts and days has been tried in the quest to find schedules that fit into every nurse's lifestyle, still meet patient care needs, and yet fit within the personnel budget and staffing model of the organization.

Cyclical schedules lend a degree of predictability to a team member's schedule (and life) by using a pattern that is repeated consistently over a certain number of weeks. Rotating shifts or permanent shifts for team members are often an issue. Rotating shifts helps share the burden of the less popular shifts and increases cooperation between shifts, but it does cause stress, depending on how often the rotation is done. Permanent shifts seem to better meet team members' needs, but a problem usually arises because most nurses may want the popular daytime shift. In that case, seniority often determines who gets which shifts. Rifts between shifts may happen with greater frequency with permanent shifts than with rotation shifts.

Control of staffing can be highly centralized, which may be more efficient and fair, or it can be decentralized to the manager level, or even down to the staff level, to better meet team members' own individual needs.

Centralized Scheduling

Centralized scheduling can apply organization staffing and scheduling policies fairly throughout nursing at a given organization, so no one individual or group

gets preferential treatment. It is sometimes easier to use float pool or per diem team members to fill empty shift spots with centralization. Data are entered about team member's preferences and on policies and procedures regarding staffing and scheduling. Staffing patterns are next identified, and patient classification data is entered. No doubt the advantages of computer scheduling include an easy-to-read schedule, fairness and consistency, and less time spent by the manager to create the schedule. However, centralized scheduling can set up a "we" versus "they" situation. Team members may not feel any obligation to solve problems in the process of staffing and scheduling because it is perceived as not their job, but the job of the central staffing and scheduling office. They may also feel that centralized scheduling lacks individual attention and that the schedule does not meet their needs.

Decentralized Scheduling

Decentralized scheduling can be done by the manager or the team members. If the nurse manager creates the schedule, he or she often becomes an expert very quickly. He or she usually best knows the needs of the unit and the team. However, it does take the manager large amounts of time to produce a workable schedule, especially if a variety of scheduling options are available to the team. One significant problem with the manager creating the schedule is that some team members may perceive that others get favored treatment. Although this may not be true, it is very easy for the manager to misguidedly use scheduling as a reward and punishment system.

NOTE

Many organizations have implemented a staffing process that combines the best of centralized and decentralized processes. The nurse managers are still responsible for completing the unit schedule and communicating staffing expectations with their team members. However, centralized support for the many phone calls and clerical aspects of the staffing process has been implemented for better utilization of a nurse manager's limited time.

Self-Scheduling

Self-scheduling by team members allows flexibility and control, which can lead to greater job satisfaction and staff retention. Criteria are mutually agreed on by the work group and then applied. Peers can negotiate and trade within the guidelines of

the unit/area and organization. Often this process is computerized or an individual team nurse or scheduling committee oversees the process. The manager usually works with the group, especially when beginning the process. Although implementation of self-scheduling is not without problems, the process usually goes more smoothly the longer it is in place. Many team members do not want to give this method up once they have worked with it.

When Staffing Problems Occur

Despite the best efforts of those creating the schedule, staffing snafus do occur. Nurse managers should be aware of the options available to deal with these crises and the fact that everyone has them, at one time or another, to a greater or lesser extent.

Sick calls are notorious for causing the manager scheduling and staffing headaches. They can be handled in a variety of ways, depending on the options available in your organization. New managers particularly will often work the shift themselves because it is the "easiest" solution. Although it may initially solve the short-term problem, working as a team member by necessity leaves other parts of the managerial job undone and may set a precedent for what to do in a "crunch"—call the nurse manager. This may ultimately hurt the team more than it helps. It is up to the manager to help the team learn that each member has a job to do that is valuable and to get them to feel a responsibility to help with staffing as much as does the manager. Sometimes the organization maintains a float pool as the first line of defense in filling staffing gaps or shortcomings.

Sometimes, if the supply of staff cannot be obtained, the manager can meet the need by working from the other side of the equation; that is, by reducing the need for staffing by transferring patients, screening types of patients that enter the system and thereby lowering acuity, or by "closing" beds.

Particularly during periods of nursing shortages, the manager might experience high vacancies on the unit. Using agency or traveling nurses has helped many organizations cope with vacancies until positions could be filled permanently. Closing, or "holding," beds may also help the situation. This practice, however, may decrease revenue for the organization if the patient goes elsewhere. The reasons for the vacancies and/or why positions cannot be filled should be thoroughly investigated and the causes fixed.

A master staffing plan (i.e., the guideline or plan by which the area is generally staffed) is usually developed for each area or unit. It is important for the manager

to secure a copy of the plan and understand its components backward and forward (i.e., in-depth). The components are the staffing pattern that gives the numbers and types of team members to schedule on each shift and the numbers and types of team members to hire to fulfill and maintain the pattern.

The design of the staffing pattern is based on a standard or statistic determined by the organization. The pattern indicates the number and type of team members that should be routinely scheduled based on an average daily census and acuity score, which dictates the hours of nursing care desired. Decisions are made about the distribution of team members by job category based on patient needs and work requirements. The pattern should be reviewed periodically to see if staffing practices need to be changed based on statistical increases or decreases or on other factors such as the strength of support departments or changes in patient mix or flow.

From such staffing patterns is built a full-time equivalent (FTE) budget to which non-productive hours are added, such as vacation, holiday, and sick hours and team member development time. An FTE is equal to 2080 hours worked per year (i.e., what a person would work if 40 hours a week, 52 weeks a year were spent working). The budget is then translated into positions that are designated full-time or part-time, and it is used as a basis to hire personnel. It is a good idea to share the staffing pattern with team members so they understand how it was developed and so they can also assist in supporting it.

On a daily basis, the nurse manager often faces the problem of trying to staff the area or unit with dwindling resources while still maintaining a good standard of nursing care. Indeed, the manager's job description usually states something like, "is accountable for staffing the unit on a 24-hour basis." Questions may arise as to the liability of the nurse manager in relation to unsafe staffing levels; to float, registry, or agency nurse errors; to team member refusal to accept a unit or float assignment; and possibly to nurses walking off the job. As background for addressing these issues, the nurse manager should become familiar with the organization's rules, regulations, policies, and procedures concerned with staffing, floating, and overtime. They will help direct decisions that must be made when problems arise. If the day comes when all options to cover an unsafe staffing situation have been tried to no avail, the next step is to communicate the inadequate staffing situation to the supervisor. The guiding principle is that of reasonableness. If the nurse manager has done everything possible to solve the problem and has communicated that fact to the appropriate persons, then she/he is most likely absolved of liability for the situation. Such situations should be documented in a report, dated and signed, and sent to the

manager's supervisor. The write-up should be factual and describe what effect the situation may have on patient care.

The use of float pool, registry, or staffing agency nurses is one way some organizations cope with and address a general nursing shortage or occasional staffing deficiencies. Keep in mind that the nurse manager has some liability for assuring nurses are competent to handle the tasks delegated to them, so the float nurses must be screened and oriented in the same way as the regular team members. Additionally, the manager should try to assign them to low-risk situations. If any question arises as to competency, the manager has a duty to report the circumstances, in writing, back to the agency. Of course, the nurse manager should follow the organization's standard operating procedures regarding communication with the agency.

What if a team member refuses an assignment or threatens to walk off the job? It is wise not to react too quickly to the situation. The American Nurses Association (ANA) has issued a position statement on "Patient Safety: Rights of a Registered Nurse When Considering a Patient Assignment" (ANA, 2009). The nurse manager should be familiar with and consider this position when handling the situation. Often the refusal or threat results from fear, anxiety, or feeling unprepared. The manager should sit down and unemotionally discuss the situation with the nurse. Find out what would make the nurse comfortable with the situation and then attempt to remedy the problem if it seems reasonable. If it does not seem reasonable, and if, after talking, the situation is not resolved, the manager should be sure the nurse has been given a clear and direct order that is not misinterpreted as a suggestion, request, or advice. The nurse should be queried as to whether the order is understood and is clear and whether he or she is refusing to do the order. The manager may want to forewarn the nurse of possible consequences if the order is refused. The consequences could be disciplinary action and perhaps even being fired, depending on the organization's personnel policies and practices.

Delegation of Nursing Tasks

Delegation of nursing tasks to unlicensed personnel was initially used as a measure to meet the demands of the nursing shortage and then as a measure to control or cut the cost of providing primary care when nursing salaries rose and reimbursement decreased. The change from "primary care" to "patient-centered team" models is where nursing advocates began using unlicensed personnel to assist with certain elements of patient care (e.g., bed baths, feeding, venipuncture) that had been accomplished by nursing assistants in the past. These team members, similar to the

home care and hospice aide in community-based care, are integral and useful and can bring new perspectives to the care planning process. However, their practice needs to be structured, supervised, and delegated appropriately. The important elements for both the nursing team and management are the training, assessment, validation, and credentialing of the unlicensed team member.

The most important element in delegation is the ability to assign to another person the responsibility and authority to complete a task with the knowledge that the individual has the capability to accomplish the task successfully. All nurses, but especially the nurse manager, need to be aware of and trust the competencies of the team members with whom they are working. The risk management of such a situation lies in whether the nurse making the assignment or delegating authority had reasonable knowledge that the team member had the competencies to carry out the task. There's no better way to establish trust between team members than to have standardized protocols and competency levels that must be met by all team members in particular job categories. Those competencies should be extended to all team members who either float or are hired temporarily from registries to provide safe, competent care on fast-paced patient care units or for home care organizations.

Finally, nurses need to rethink roles and rid themselves of the widely held belief that nurses are the *only* ones who can provide the best care. They need to learn to view themselves as the *leaders* of the work group, rather than the work group itself, and focus on what they do best: assessing, critically thinking, planning, and evaluating the care that a patient receives. Nurses cannot do it all alone, especially when caring for very sick patients across the care continuum.

Credentialing and Competency

Credentialing continues to be a major issue for all professional and licensed or certified staff. Credentialing encompasses licensure, accreditation, certification (ANCC, n.d.), and academic degrees. The nurse manager plays a major role in ensuring that the team members practicing in their area are competent to care for the assessed needs of the unit/area's patients. Credentialing came about because it benefits and protects the patient by ensuring that the nurse has certain minimum skills and abilities. A professional license may ensure skills and abilities or entry into practice, but it *does not validate current or guarantee ongoing competency*. With medical and nursing practice changing so rapidly, additional credentialing and educational activities should be added to licensure to ensure ongoing competency.

Usually during an orientation period, the orientee meets performance standards. A skills inventory is completed after satisfactory demonstration of skills (e.g., validation) such as patient assessment, care planning, or medication administration, and this is maintained in the personnel/HR record of an individual nurse. This inventory needs to be dated and signed. The skills inventory, or competency checklist, provides legal documentation of professional skills competency. Additional specialty courses may be completed and tests taken that show mastery of the material (e.g., fetal monitoring or group therapy facilitation). The nurse manager's role is to ensure that this process happens, all the way through to filing the results. Sometimes the skills inventory will be distributed, explained, and even completed, but never make it into the personnel record. It is for this very reason that individual nurses should also maintain such records.

The nurse might need to undertake remedial study if deficiencies are identified through critical incidents. It may be up to the manager to see that a plan is formulated with the individual nurse to correct deficiencies and attain the necessary skills and knowledge to improve performance. Competency evaluation is an important tool in the CQI process. An ongoing program of education and evaluation of both the general and the specialized skills of team members is needed to ensure quality outcomes. It is important that the nursing team understand why their competence is being checked/validated and that they participate in the determination and development of the plan for ensuring and maintaining competency.

Another aspect of credentialing is external certification. Many nursing specialty organizations have a mechanism for and offer certification. The nurse takes a test and, in some cases, must provide proof of a minimum number of hours and type of clinical experience. Attainment of certification ensures a certain level of knowledge and expertise and should be encouraged among your team.

Many organizations promote external certification by reimbursing nurses or by making it part of the requirements for a higher level within a clinical ladder system. Review courses associated with particular tests may also be administered in the organization. Manager support of external certification helps the team pursue this additional level of professional expertise, which then benefits the patients and families.

Meetings

All organizations hold meetings of one type or another, and healthcare systems are no exception. Because the nature of the business usually encompasses 24 hours a day,

7 days a week, with a multitude of departments and disciplines participating, the need for meetings may be higher than in other business sectors.

New nurse managers must acquire the skills to either lead or help others to lead meetings. Gone are the days when a manager issued a dictum without consulting others in the work group. Group problem-solving activities and planning for change with group consensus are common practices, and leaders are needed to make the meeting processes efficient and collaborative and to help ensure the best outcomes.

Team Meetings

In general, the most common meeting a new nurse manager will lead is the team meeting. Purposes of a team meeting vary depending on the situation for which the meeting is called (see Table 4.2). Identifying the purpose is important because it assists group members in knowing what is desired of them and gives the nurse manager some guidance on what leadership techniques to use.

TABLE 4.2 PURPOSES OF TEAM MEETINGS AND LEADERSHIP TECHNIQUES TO USE FOR SUCCESS

Pattern	Techniques
Providing information (manager to group)	Be sure the group understands what has been told to them by soliciting questions, approval, criticism, and so on.
Receiving information (group to manager)	Ask clear questions and listen. Use a "round robin" technique to solicit information from less verbal group members.
Interactional (group and manager)	Combination of above.
Problem-solving/decision-making	Help group identify real problem. Use brainstorming techniques for alternatives. Get consensus of solution. Ensure actions are assigned.

Meetings are expensive when the salaries of all involved are analyzed. Manager's Tip 4.2 describes behaviors for leading effective meetings. Attendees at the group team meeting are usually chosen according to the philosophy of the organization and past practice. Options include meeting with only the members of a particular position (i.e., RNs or nursing assistants), all team members from a particular shift, or the total team. There are pros and cons for each grouping.

MANAGER'S TIP 4.2

12 BEHAVIORS FOR LEADING EFFECTIVE MEETINGS

- *Prepare by drawing up an agenda well before the meeting, posting it, and allowing addition of items by the team. Identify the purpose of the meeting.*
- *Be sure all agenda items are necessary. Some might be better addressed in a memo, posted on the bulletin board, or dealt with on a one-to-one basis.*
- *Start and end promptly. Keep on schedule. Close the discussion if necessary, but be prepared to address unfinished business later.*
- *Clarify and summarize discussions and decisions so the group is clear on outcomes. Lend structure to the discussion.*
- *Ask vocal members to allow others to contribute. Encourage the less vocal members to talk.*
- *Keep a neutral, friendly, and respectful attitude while leading. Use active listening skills. Thank everyone for attending.*
- *If necessary, request that arguments, criticisms, and side conversations be held until after the meeting.*
- *Set up an environment conducive to the meeting, including coffee (or food), adequate ventilation, room temperature, and seating. Interruptions should be kept to a minimum.*
- *Have all handouts available, including the agenda.*
- *Ensure that minutes are taken and distributed after the meeting.*
- *Know that there may be more agenda items than time to discuss them all.*
- *Prioritize agenda items and adhere to the prepared agenda.*

Small groups of 4 to 12 people seem to work best. However, it is best to allow the group as a whole to decide who should attend the team meetings. They should also determine the frequency, time of day, day of week, and length of the meeting.

The documentation of team meetings (minutes) provides written evidence that accreditation standards are being met. Thus it is vitally important for the team meeting minutes to be accurate, specific, and detailed as to discussions, decisions, action plans, and so on. Examples of information included in the meeting minutes might include policy reviews, a patient case conference, QAPI projects and progress, and more.

The suggestions in Manager's Tip 4.3 describe important points to document in team meeting minutes. Also, make sure to retain the minutes from the meetings and also follow the organization's record-retention policy.

Two issues frequently arise in relation to team meetings that the new nurse manager must address: (1) the lack of attendance at team meetings, and (2) pay for attendance. In the former case, the team should address the problem to determine the causes and solutions. Absenteeism may be related to inconvenient meeting times, inefficiently run meetings, or several other problems. Some organizations annually evaluate meeting structure to assist in meeting team member needs. Regarding the second issue, most organizations have pay policies that outline whether team members are paid for time spent at team meetings when the meetings are outside the employee's normal work schedule. If the organization doesn't have a policy for this, HR and/or nursing administration personnel would need to develop a policy because it would affect the budget throughout the nursing department, if not the entire organization.

At times, the new nurse manager may lead other groups in addition to their team. These may include ad hoc groups formed to address specific issues or goals of the department or organization. The nurse manager can apply the principles for leading team meetings to leading these groups as well.

MANAGER'S TIP 4.3

Important Points to Document in Team Meeting Minutes

- *Who did and who did not attend.*
- *Issues discussed and decisions regarding the issues, with an emphasis on those related to patient care.*
- *Quality improvement monitoring results, including conclusions, recommendations by the group, and action plans. The group, highlighting their own involvement in the process, should identify the process for evaluation. When problems are corrected, this should be identified in the minutes.*
- *Any issues relating to patient care standards, standards of practice, or patient care delivery systems should be detailed, along with resultant decisions and actions.*
- *Reports by team representatives on committees should be documented.*
- *Any tools, models, visuals, or graphics that support the information/content of the meeting.*

Case Conferences

In today's fast-paced, complex, highly regulated healthcare environment, it is essential that patient care be administered efficiently so that positive patient

outcomes can be achieved as rapidly as possible. Case conferences help in this process by assisting in the coordination of care for the patient among all the disciplines involved. Holding a case conference can often eliminate duplication of efforts and unnecessary confusion and frustration for the patient, family, and healthcare team.

Although the primary nurse or the RN most closely associated with the patient usually leads the conference, the nurse manager definitely has a role to play in the process. The nurse manager encourages, validates, and acts as a resource person. Various members of the healthcare team may participate, including the physician, social worker, utilization review nurse, pastoral care representative, therapists, dietitian, home health nurse, and any others deemed necessary.

Often the family and the patient participate in the conference as well. Once someone on the team (or the patient/family) decides a clinical conference is necessary, a leader is chosen, persons who should attend are identified, and a mutually accepted date and time are chosen. A conference room is procured. Arrangement may need to be made to cover the RN's assignment during the conference. At the beginning of the conference, attendees are introduced, the purpose is highlighted, and the leaders provide a brief overview of the patient's status, encouraging others to contribute additional data. Issues are identified, alternatives discussed, and an action plan formulated. Consensus is reached regarding follow-up, evaluation plans, and the need for further meetings. The whole (revised) plan should be in the patient's record for easy access by all healthcare team members.

Documentation of the case conference should go beyond writing the action plan in the patient's record. Consistent documentation of attendees and the process and outcome of the conference will help demonstrate meeting these accreditation standards on care coordination.

Rounds in the Clinical Area

Rounds made by the nurse manager in areas where care is given can accomplish several things in a relatively short period. The nurse manager can observe nursing care and performance of team members in practice and compare them to standards, and conversing with patients and families allows assessment of patient satisfaction with care. The manager can also check the environment regarding compliance with public health and safety standards and survey the area for aesthetic or other problems.

Although there is no hard-and-fast rule, it is suggested that nurse managers complete rounds daily (at a minimum), which allows observations to occur over a long period. It also helps to prevent the pitfall of drawing erroneous conclusions based on limited observations. Times of rounds during the day or night can be varied. Making notes during rounds assists in following up on issues identified. Team members see the nurse manager as they work and may be more prone to bring up new issues when they see the manager.

Rather than putting patients on the spot with pointed questions concerning their perceptions of quality of care, ask less threatening, open-ended questions such as, "How is everything going?" "What is going on?" or "How are you doing?" If a patient's answer indicates the possibility of a problem, the manager can focus the questioning further to get to the problem.

The manager should review public health and safety standards by meeting with the person in the organization that is most knowledgeable about them. One suggestion is to make a checklist from the standards that can be used during rounds to assess compliance. Aesthetic issues, such as broken or tattered furnishings or building materials, can be noted during rounds. The manager should view the unit or area as a patient or family would view it (similar to a hotel) and pass a list of deficiencies to the responsible department. Consider bringing in an objective person and asking for her/his assessment of aesthetics and requesting feedback for improvement.

Usually during rounds, the nurse manager will compile a list taken that will have several items on it that will require follow-up.

Prioritizing Duties and Time Management

A manager's work is never done, and there is never enough time to do it. These concepts are difficult for a new nurse manager to accept. By the end of the day, as a team nurse, most likely all one's tasks were finished. The nature of a manager's work is longer-term, and projects and activities may take more than a day, sometimes months, occasionally years, to complete. On a daily basis, managers must decide what activity or project takes precedence over another as they are faced with multiple and sometimes conflicting demands. How does the new manager prioritize the schedule? Manager's Tip 4.4 presents some suggestions to help manage tasks and time.

MANAGER'S TIP 4.4

Dealing with the Workload

- *Make a to-do list (written or electronic).*
- *Organize your office.*
- *File agendas and minutes (paper or electronic) of all meetings you attend.*
- *Delegate activities to others when possible.*
- *Determine whether problems are yours or another's to solve.*
- *Organize communication with team members by using the most effective method for your unit.*
- *Use a calendar to keep track of standing meetings, lunch, and other appointments.*
- *Schedule time in your calendar to plan and organize.*

Issues surrounding patients, such as patient complaints, staffing issues, or concerns related to supporting patient care, should be addressed promptly. Patient, family, and team concerns usually take priority over preparing for a meeting or justifying a budget variance.

At the beginning of each day, create a to-do list in descending order of priority. Unanticipated problems may occur throughout the day, so priorities will need to be reset. This is common practice that's really no different from when the manager was a staff nurse.

One trap new nurse managers fall into is that of trying to solve everything for everyone. In their eagerness to prove themselves to their subordinates, they take on too many responsibilities. The result is a frustrated manager. Be very careful of reverse delegation by your team. It is wise to adopt a coaching attitude, assisting them in solving problems and implementing solutions, rather than accepting all the problems as your own responsibility. Solving problems can help the team grow professionally and gain a different perspective.

Documentation

The Merriam-Webster Dictionary (documentation, n.d.) defines *documentation* as "the act or an instance of furnishing or authenticating with documents…the provision of documents in substantiation...." This simple definition fits all the

varied and important roles that documentation, or the process of documenting and demonstrating delivery of patient care, assumes in healthcare. Nursing entries that appear in the medical or clinical record reflect the standard of nursing care, as well as the specific care provided to the patient. Other healthcare team members make decisions for further care based on the nursing entries. Also, numerous third-party payers make legal and quality judgments, as well as administrative and payment decisions, based on the clinical record. Nurses have many responsibilities, all ultimately directed toward patient care. Because of these responsibilities, the actual task of documentation must sometimes be relegated to the end of the shift. Electronic medical records (EMR) have assisted greatly with supporting real-time documentation.

The Professional Nurse's Role in Documentation

The professional nurse's entries in the patient's clinical record are recognized as a significant contribution to documenting the standard of care provided to a patient. As the practice of nursing has become more complex, so have the factors that influence the purposes of documentation. These factors include the requirements of regulatory agencies, health insurance payers, accreditation organizations, consumers of healthcare, and legal entities. The nurse must try to satisfy these various requirements all at once, often with precious few moments in which to accomplish this important task.

Any nurse writing a clinical entry today could be trying simultaneously to meet the standards of the accrediting body, various insurers, state and federal laws and regulations, and other professional organizations. Fortunately, most hospitals have integrated many of these requirements into hospital policy or procedure manuals and EMRs.

The clinical record is the professional nurse's best defense against litigation when malpractice or negligence is alleged. The increased specialization of healthcare providers and the complexity of patient problems and associated technology have contributed to varied services being provided to patients in a shortened time frame. The patient's record is the only source of written communication, and sometimes the only source of any communication, for all team members. The members not only contribute their individual assessments of interventions and outcomes, but also base their subsequent actions on the record of events provided by other team members.

As such, the actual entries must be recorded as soon as possible—for example, after a change in the patient's condition is noted, when the physician is notified, when an intervention occurs, or when a response to the treatment is observed. Nurses can have their practice well represented and quality demonstrated through thorough, effective documentation. The sidebar explains the importance of outcome criteria, process, and standards of care to such documentation.

KEY TERMS RELATED TO DOCUMENTATION

- **Outcome criteria:** Outcome criteria are the desired results on completion of the objective (or demonstrable) evidence observed at the end of care (e.g., a patient's anticipated knowledge or activity level on discharge). In a specific case, a patient with diabetes mellitus returned to self-care status. Outcome criteria include that the patient demonstrated all activities noted on the diabetes mellitus checklist on discharge and the patient verbalized that initial complaints were resolved and needs met.
- **Process:** A process is specifically how the care is provided. An example is a standard that requires that patients receive a complete assessment within so many (specific) hours of admission. The specific parameters that must be included in the assessment are also identified.
- **Standards of care:** There is a growing emphasis on the standardization of care and related processes. This also includes policies and procedures. All patients or clients are entitled to a certain level, or standard, of care. As patients become more proactive consumers in the purchase of healthcare services, the patient experience becomes the key to the organization's reputation and ultimate survival. Nurses, because of their healing skills and other areas of proficiency, are pivotal in fostering positive patient experiences. The roles of the nurse as patient advocate, listener, and teacher have become widely accepted. With these roles come the responsibilities of maintaining the hallmarks of any profession. These include licensure, education, certification or other credentialing processes, and other ongoing educational requirements. Standards of care in nursing are varied and include nursing specialty association standards and national, state, and local standards that define the acceptable level of practice. These standards are vital to the professional nurse's ongoing education. For this reason, it is important that the nurse remain informed on all areas of practice that affect the provision of care.

Function of the Medical/Clinical Record

Clear documentation in the medical/clinical record is highly important because this record is:

- The only written source that chronicles a patient's stay from admission through discharge
- The primary source for reference and communication among members of the healthcare team
- The only documentation that supports insurance coverage payment or denial
- The only evidence of the basis on which patient care decisions were made
- The only legal record
- The foundation for evaluation of the care provided
- The basis for team member education or other study
- The objective source for the organization's licensing and accreditation review (e.g., TJC, etc.)

Many complex factors have contributed to an environment in which the nurse has increased responsibilities for documentation and a shortened time frame for producing the documentation, in part because of the decrease in patient lengths of stay. This written record is the only account of a patient's stay. Many processes involve the CQI/clinical record for these reasons. Documentation should be completed at the time of care to prevent the loss of valuable information. For those practicing in home care, see *The Handbook of Home Health Standards: Quality, Documentation, and Reimbursement* by Tina Marrelli (Marrelli).

Legal Issues and Risk Management Considerations

Discussion of legal issues in nursing management could fill several books, and it is often difficult for the new nurse manager to know where to focus attention in terms of legal issues. In addition, the new manager's difficulty in discerning significant legal issues may be further complicated by the team's initial tendency to raise numerous questions or concerns about legal issues. Understanding the legal aspects of supervision can help the nurse manager provide such leadership and allay team members' concerns.

Legal Aspects of Supervision

Nurse managers are generally responsible for the acts and omissions of all nurses and unlicensed assistive personnel whom they supervise. This falls into the category of negligent supervision.

One exception to this rule occurs when, despite appropriate supervision, practitioners take it upon themselves to do something that is entirely outside the scope of their job functions. A classic example of this conduct involves nurses who voluntarily provide care to patients in their homes after they have been discharged from the hospital, organization, or home health agency. As long as management is able to demonstrate that a policy was established that prohibited this conduct, liability for injuries to patients during such "detours" will most likely rest solely with the practitioners.

State laws control the delegation of allowable functions to certain types of practitioners. That is, state licensure statutes govern which functions related to patient care may be delegated to which types of practitioners. Nurse managers must thoroughly understand these statutes in the states in which their organization provides services in order to ensure that functions are properly delegated. Any questions or areas of uncertainty should be referred to the appropriate state licensure boards for written clarification.

Many nurse managers are understandably concerned about the scope of their responsibilities for everyone who falls within their chain of command. They certainly cannot provide direct supervision to each practitioner whom they supervise on a daily basis. This valid concern serves to reinforce the importance of hiring and retaining practitioners who provide care to patients in an appropriate manner. It also underscores the need to take prompt disciplinary action with regard to practitioners who do not meet established standards.

Even though every practitioner's actions cannot be supervised directly, significant legal issues exist that always merit the attention of competent nurse managers. New managers should immediately focus their attention on these issues and continuously monitor developments in the following three areas:

- Professional negligence
- Consent to treatment, including the patient's right to refuse treatment
- Employment issues

Professional Negligence

Healthcare providers often equate negligence with something going wrong. In fact, there are risks associated with treatment. Just because something goes wrong does not mean that any legal liability exists. Rather, there are four components that every patient must be able to prove were involved to show that nurses were professionally negligent:

- Duty
- Breach of duty
- Causation
- Injury

All four of these components must be involved to prove professional negligence. If patients fails to prove even one of these elements, they lose their cases. Thus these elements can serve as a checklist for the new nurse manager to use to manage risks and evaluate the likelihood of legal liability. If even one of the components can be defeated then no legal liability exists.

A determination that there is no legal liability is certainly not all that should concern the nurse manager. Managers may have significant ethical, quality assurance, employment, and licensure concerns that should be pursued even when no legal liability exists. However, it is helpful to eliminate concerns about legal liability even when other serious considerations require resolution.

It is also important to remember that these elements constitute the definition of professional negligence used by the courts. That is, when courts attempt to determine whether providers are negligent, they consider these elements in relation to each case to determine liability. The legal definitions of duty, breach, causation, and injury are discussed in the following sections.

Duty

Duty is the obligation owed by providers to their patients. Thus the existence of a provider-patient relationship is a prerequisite to potential liability. There are two standards that a nurse needs to know in relation to duty: standards of care and standards of practice.

The first is the overall *standard of care*. This is a legal standard and includes the obligation owed by nurses to their patients. A nurse owes a duty of reasonable care to patients. Of course, the key question then becomes: What is reasonable?

The law defines the overall standard of care for a nurse as what other ordinary, reasonable, and prudent nurses would do in the same or similar circumstances in the same or similar community.

Nurses know what other nurses do by adhering to standards of practice. *Standards of practice* also define nurses' duties to their patients and are used to determine whether a nurse's conduct in a particular patient care situation met or did not meet the overall standard of care. Sources of such standards of practice are:

- Standards of professional nursing organizations such as the ANA and the National League for Nursing (NLN)
- Court decisions
- The employer's internal policies and procedures
- State licensure statutes
- Requirements of third-party payers
- Standards of accreditation organizations such as The Joint Commission (TJC)

The Importance of Policies and Procedures

Policies and procedures are an important source for both standards of practice and the overall standard of care. Developing appropriate standards of care through policies and procedures is certainly a double-edged sword for nurse managers. Although it provides an opportunity to establish standards that are appropriate for institutions and team members, it also allows the law to determine if they have been met.

In addition, developing policies and procedures is an exceptionally tedious task for several reasons. Some nurses believe that policies and procedures should cover every possible contingency associated with the policy subject. Nurses who share this belief want such policies so that they feel they have clear guidance. Other nurses, however, believe that policies and procedures should provide only broad guidance, within which nurses should exercise appropriate professional judgment. Obviously, finding a balance between these two competing goals is necessary. Policies that are too detailed often prove useless because team members do not have the time or

inclination to read through volumes to understand procedure. Conversely, promoting clarity of expectations for team members is one of the basic tenets of effective nursing management.

Developing standards of practice through policies and procedures is further complicated by the sheer number of individuals and committees that typically review a new or revised policy or procedure. Often, what goes into the process bears little resemblance to the final result.

Despite these obstacles, the nurse manager must persist in developing and maintaining appropriate policies and procedures. A key to success is to avoid thinking that this process is ever complete. Nursing policies and procedures are under almost constant review and scrutiny; they are not static. Rather, they change often because of experience, judgment, and new clinical developments. Manager's Tip 4.5 presents key steps for managing risk through policies and procedures. If nurse managers follow these steps, they will have greater assurance that they appropriately manage risk by careful definition of duty in terms of policies and procedures.

MANAGER'S TIP 4.5

5 Key Steps to Managing Risk Through Policies and Procedures

1. *Review policies and procedures at least annually.*
2. *Involve different team members in reviewing policies and procedures so that various points of view are obtained and the team has an opportunity to review standards of care.*
3. *Make needed changes promptly.*
4. *Ensure that all team members are informed of changes in policies and procedures.*
5. *Ensure that all new team members read and understand the policies and procedures.*

Breach

Nurses may breach their duty to patients by doing something they should not do, which is commonly referred to as an *act*. They may also fail to do something that they should do, which is often referred to as an *omission*. In many malpractice cases, patients are able to prove that the providers committed more than one act or omission. Yet, they need to prove only *one* act or omission to prove a breach.

Causation

A patient must show that the act or omission of the nurse caused injury or damage. The best way to define *causation* is in terms of "but for." That is, but for the action or inaction of the provider, the patient would not have been injured. Another way to consider causation is in terms of what courts call "foreseeability." That is if providers should have foreseen that their act(s) or omission(s) would cause injury or damage to a patient, the injury was foreseeable and therefore may have been caused by the providers. Conversely, if providers could not have foreseen that their act(s) or omission(s) would cause injury or damage to a patient, the injury was not foreseeable and therefore may not have been caused by providers.

Time is certainly a consideration with this requirement. For example, when a patient who is released from a mental health institution causes injury or damage to an individual after release, it is tempting to find a causal connection between the patient's release and the injuries sustained. Nurses recognize, however, that an individual's mental status may change very rapidly. Therefore, no causal connection may exist between release and the injuries.

Injury

To be held liable, nurses must injure or damage their patients, either physically or emotionally. Courts have evidentiary requirements that must be met to prove injury, and patients often have difficulty proving non-physical injury. It is not the job of the courts to address all inconsequential irritations and inconveniences.

The common types of negligence are:

- Failure to properly monitor and observe patients
- Improper diagnosis, particularly meningitis in pediatric patients and myocardial infarctions
- Falls
- Foreign objects left in patients during surgery
- Negligent premature discharge

Negligent Premature Discharge

Negligent premature discharge is typically directly related to third-party payer activities. Whereas providers previously made decisions regarding patient care, payers are now the gatekeepers to the healthcare delivery system. In view of this, providers question why they may be held liable for the results of payment decisions of payers.

In response, payers argue that they do not write orders, including discharge orders. Providers are free to render as much care as they determine patients need. Payers are saying only that they will not pay for such care. Further, payers argue that, in many instances, they are simply enforcing a contract of insurance. Once benefits required by the contract have been provided, they are under no obligation to pay for additional care, regardless of the clinical condition of patients. Providers, however, recognize the reality of the healthcare delivery system today, which is that payment decisions are, in essence, treatment decisions.

Informed Consent

There are two forms of *informed consent*: express and implied. Express consent can be oral, and should be documented as such. Most healthcare facilities, however, utilize express consent in the form of a written consent form for any and all patient care.

Implied consent often exists as well. If a nurse goes into a room to take a patient's vital signs, draw blood, or do a physical assessment of the patient and the patient does not object, implied consent has occurred.

Implied consent is also seen in the emergency department or when emergency care is needed. In such situations, consent is implied because delaying treatment for the purpose of obtaining consent when the patient's life is at stake is not appropriate.

Express written informed consent is required for all treatment other than in those specific situations. This is true regardless of any risks inherent in the treatment.

The following two prerequisites must be met to obtain valid informed consent:

- The patient must have the capacity to give consent in terms of chronologic age and the ability to understand information.
- The patient's consent must be voluntary.

Generally, patients must be of legal age before they can consent to treatment. The age at which an individual is legally considered to be an adult varies from state to state but is usually at either age 18 or 21. Exceptions to this requirement include:

- Minors who are emancipated because they are married, have borne a child, or are economically independent. The laws on this category vary from state to state.
- Minors who seek treatment for certain types of conditions such as sexually transmitted diseases, mental illness, or substance abuse. Laws regarding these exceptions also vary from state to state.

Patients must also be able to understand information to give valid consent. Generally, this requirement means that they must be able to understand the consequences of their choices regarding treatment. Patients who have been found to be incompetent by the courts clearly lack capacity to understand information. Patients who have not been declared incompetent may, nonetheless, lack the necessary level of mental capacity. The best method for evaluating capacity is to use a mental status examination, conducted by an appropriate practitioner (e.g., psychiatrist, psychologist, or other team members such as a nurse practitioner/clinical nurse specialist specializing in psychology), and to document the results in patients' records just before obtaining informed consent.

You should note that the law recognizes that *capacity* (the ability to understand information) may vary from moment to moment. Confused patients may suddenly seem much more lucid. It is appropriate to seek informed consent during such moments. Consent under such conditions *is generally viewed as valid* even after the patient becomes incapacitated once again.

A patient's consent must be voluntary (i.e., there can be no fraud or duress). Providers cannot tell patients that they are going to perform one treatment and actually perform an entirely different treatment.

When obtaining informed consent, the provider must give a description of the proposed treatment because consent is valid only when a patient understands the treatment to be received. A patient cannot provide valid consent to a treatment that she or he does not understand.

Benefits of the proposed treatment must never be described in absolute terms or as guarantees of results. If benefits are presented to patients as guarantees, a contract may be created that is breached by providers if they fail to deliver the promised result. Providers must speak of *possible* benefits from proposed treatment.

Information needed for informed consent is:

- Name and description of the proposed treatment
- Possible benefits of the proposed treatment
- Significant risks associated with the treatment
- Description of alternative treatments
- A clear acknowledgment of the patient's right to refuse treatment
- Implications if refusal of treatment is selected

A provider is not required to share *all risks* with patients. Rather, a provider is required to share those risks that are either statistically significant or are especially important to patients in the provider's opinion. For example, if a proposed surgery involves even a slight possibility of injury to a musician's hands, this risk must be disclosed.

Alternative treatments must also be described. These may include medications, physical therapy, surgery, diet and exercise, or whatever could be of benefit to the patient.

Finally, the unqualified right of patients to refuse any treatment must be acknowledged as part of the process of obtaining informed consent. Providers should make a clear statement to this effect, which should be specifically acknowledged by patients.

Patients who consent to treatment after the prerequisites have been met and the required information has been given have given valid informed consent. It is important, however, to document the patient's consent. Providers use several methods to accomplish this goal. The most popular vehicle is undoubtedly a consent form, which is useful only when it documents the specific information given to the patient. Other providers use progress notes summarizing the consent process. Audio and video recordings are also acceptable means of documenting informed consent.

Nurse managers should understand that it is the physician's job to obtain valid informed consent prior to treatment or procedures. Nurses may ask patients to sign forms documenting that they have given informed consent. Their signature on such forms as witnesses means that they saw the patient sign the form; their signature does not verify that patients received appropriate information. But nurse managers must also realize that the nursing team has a vested interest in making sure informed consent is obtained because healthcare is almost always provided as a team. When

one member of the team fails to perform or to adequately protect the team, the whole team is at risk, not just one member.

Suppose, however, that patients cannot meet the prerequisites of informed consent because of their chronologic age or lack of ability to understand information. Who may give substitute consent on behalf of such patients?

- **Parents on behalf of minors:** In the case of separation or divorce, either the custodial or the noncustodial parent may consent unless she or he is prohibited from doing so in a separation agreement or a divorce decree. Nurse managers should educate team members to obtain copies of relevant documents and to place copies of these documents on patients' charts to certify that appropriate individuals gave consent on behalf of minors.
- **Courts**
- **Guardians of the person:** Courts appoint two types of guardians or conservators: guardians of the property and guardians of the person. Only guardians of the person may consent to healthcare. Team members must obtain a copy of any decree of guardianship and place it on the patient's chart to document valid informed consent.
- **Attorneys-in-fact:** Attorneys-in-fact are appointed to act on behalf of patients in powers of attorney. Powers of attorney are very flexible instruments. Nurses must therefore obtain a copy of any power of attorney under which an individual claims authority to evaluate the scope of their powers. Only patients who have mental capacity may execute powers of attorney. When patients become permanently mentally incapacitated, it is too late to sign a power of attorney. Durable powers of attorney survive the incapacity of patients. The laws governing powers of attorney survive the incapacity of patients and vary from state to state.
- **State statutes:** Some states have passed laws that permit individuals to make decisions regarding healthcare in the absence of a guardian or attorney-in-fact. There is significant variation among the state statutes.

Patient Self-Determination Act

The Patient Self-Determination Act (PSDA) took effect December 1, 1991. The act requires providers to provide written notification to patients of their right to refuse or consent to medical treatment. While compliance with this act may seem as simple as giving patients written notice, the purpose is to increase communication and empower patients to make decisions that support their personal goals.

The nurse manager should recognize that conversations regarding treatment decisions may be challenging for some team members, and extra support should be provided until a nurse is comfortable supporting patient decisions, even when they are not aligned with the nurse's beliefs.

It is important to know state laws and your institution's policies regarding the transferability of Do Not Resuscitate (DNR) or Allow Natural Death (AND) and "Out of Hospital DNR/AND," which are orders written by a physician in the community versus in an inpatient facility.

HIPAA Considerations

The Health Insurance Portability and Accountability Act (HIPAA) was signed into law in 1996. The administrative simplification provisions of this legislation, including the transactions, privacy, and security rules, have a significant impact on the daily operations of most healthcare entities.

The Transactions Rule

The transactions rule is the driving force of the administrative simplification provisions. Its goal is to increase the efficiency of the healthcare industry by mandating standard formats and code sets for electronic transactions. By doing this, healthcare providers, health plans, and healthcare clearinghouses will be able to communicate with each other more effectively and use technology more efficiently. At this time, the requirements of the transactions rule mostly affect billing departments and software vendors.

Implementation of the transactions rule provides incentive for healthcare entities to move from paper-based systems to EMRs. This raises, however, many concerns about the privacy of a patient's health information and the security of information systems. The privacy and security rules address these concerns, and compliance with their requirements necessitates not only many operational issues, but also the development of a culture within the organization of a commitment to the protection of the privacy and security of a patient's health information.

The Privacy Rule

The privacy rule delineates permitted and required uses and disclosures of patient health information and describes rights that patients have with respect to their health

information. The following is a brief overview of some of the major components of the privacy rule that are evident in the daily operations of healthcare providers:

- Information related to a person's health that could identify that individual is protected and may only be used or disclosed as permitted or required by the privacy rule.
- Protected information includes information in written, electronic, or verbal forms.
- A notice of privacy practices, a document describing how the provider uses and discloses a patient's health information and a description of patient privacy rights, must be provided to all patients at the start of care.
- Every healthcare provider must appoint a privacy official, who is the focal point of accountability for all privacy-related matters.
- All members of the provider's workforce (including volunteers) must use only the minimum amount of protected information needed to perform their job effectively.
- All members of the provider's workforce (including volunteers) must receive privacy training soon after they begin working for the organization.

There are many other procedural requirements of the privacy rule that are designed to ensure that healthcare providers have systems in place to protect patient health information and accommodate patient privacy rights. The Office for Civil Rights has detailed information on these requirements available on its website.

The Security Rule

Privacy and security are very closely related. It is not possible to protect the privacy of health information if adequate security mechanisms are not in place. The purpose of the security rule is to safeguard the confidentiality (that it remains private), integrity (that it is not altered in an unauthorized way), and availability (that it is protected from loss or destruction) of electronic protected health information. The security rule applies only to protected health information that is stored or transmitted electronically.

The security rule requires that administrative, physical, and technical safeguards to protect electronic health information are implemented. The security mechanisms selected by healthcare providers must be based on a thorough assessment of vulnerabilities and careful decision-making related to how to minimize the potential for identified risks materializing.

The following is a brief overview of some aspects of the security rule that are evident on a daily basis:

- A security officer is appointed. This person is the focal point of accountability for all matters related to the security of information systems and the safeguarding of electronic health information.
- Access to controls is in place to ensure that only those who are authorized are able to access electronic health information.
- Security awareness training is provided on an ongoing basis to ensure that members of the workforce understand password management, virus protection, and policies and procedures related to work station use and security and reporting security incidents.
- A contingency plan is in place and regularly tested to ensure the continued availability of electronic health information in the event of a natural disaster or other emergencies.

A Summary of HIPAA

The administrative simplification provisions of HIPAA are laws. Compliance is not optional, and there are significant civil and criminal penalties for privacy or security violations. Nurse managers must do their part to ensure that those they supervise understand their responsibilities with respect to the privacy and security of patient health information. More important, the requirements of the privacy rule and the security rule are intended to restore public confidence in the privacy and security of health information, and it is the responsibility of nurse managers to contribute to the development of a culture of privacy and security within their organization.

Computerization/Management of Information Considerations

Patient-centered, cost-effective care has driven another industry to the forefront of healthcare: information services. Manual, paper-heavy documentation systems are unwieldy in terms of getting information to where it is needed—the site of patient care. From the acute care setting to the outpatient facility to the physician's office to the patient's home, accurate information is needed quickly. Adding to this burden is the specter of health organizations merging, affiliating, and growing by leaps and bounds. The use of computers with patient care databases is needed to move

the patient safely and effectively along a care of continuum, reducing unnecessary duplication of tasks and procedures, and quantifying appropriate outcomes and variance data in order to continually improve care processes.

Information systems for healthcare settings should include financial reporting as one element of the total product. Patient care planning and acuity systems, based on data generated and input from the patient assessment, allows for more accurate scheduling and staffing systems. Data entry of physician orders (charge entry) should flow to all affected departments for appropriate service scheduling. As clinical protocols and outcome data are entered, appropriate variance collection and trending can be done, with resultant variance analysis as an integral part of a CQI system.

As a nurse manager in any healthcare setting, you may be asked to assist in the assessment of information systems for your organization. The checklist in the sidebar, which can be used in any setting, includes some of the issues you should want addressed or have information about during these planning and review sessions.

INFORMATION SYSTEM PLANNING/REVIEW CHECKLIST

- Establish goals, priorities, and outcomes of an information/technology system—who are the end users?
- Budget guidelines
- Timelines for implementation
- Future capabilities of system to expand or interface with other care sites
- Impact of documentation on team members (time, learning curve, costs, etc.)
- Reduction of documentation—not duplicating information
- Security/confidentiality features of system—HIPAA compliant
- Acuity, patient care planning, clinical paths or protocols integration
- Support of vendor and information services
- Training needs of team members or end users
- Commitment of resources for training and re-inservicing of team members as needed

- Ability to modify system with customized settings
- Existence of ongoing information services committee and patient care team member involvement
- Decrease in productivity during implementation/learning phase
- Enhancements and upgrades
- Names of other users of this system to use as references for quality, support, and functionality of the system
- Monitoring for inappropriate access
- Compliance with regulatory meaningful use reporting

Unique Challenges in Home Care

"The home environment brings with it some unique dynamics that must be fundamentally understood for success" (Marrelli, 2017, p. 45). Nurse managers who are responsible for "distance" management must add additional, unique tools to their skill set in order to effectively manage team members that are in the field. From the onset it can be surmised that directing team members that you may not see daily (or even weekly!) creates a different relationship that is based on trust, knowledge of the home care fundamentals, and experience.

The unique features of home care include patient control over the environment and the nurse as a "guest" in that environment. The multifaceted administrative and clinical operations that must be maintained to provide patient care in the community setting are the core of the home care manager's responsibilities. Increased duties, responsibilities, and skills include:

- An in-depth knowledge of the current regulatory environment, including the Medicare Conditions of Participation (COPs) and state surveyor interpretative guidelines for compliance, the state Certificate of Need (CON), and licensure laws, where applicable.
- Knowledge of the status and source of accreditation and the complex "rules" that are synonymous with home care, including the Medicare Benefit Policy Manual, the specific provisions for eligibility coverage, and the documentation requirements.

- Knowledge of the billing procedures and rules that dictate the administrative structures and processes necessary to support timely and accurate billing. The administrative skills needed to orchestrate the many steps that must occur require flexibility. A structure that moves the process forward regardless of staffing problems or other operational problems is demanded.
- A repertoire of service-driven and patient-oriented interpersonal skills. Unlike inpatient organizations, where the structure defines the services, in home care the patient's needs are the criteria that drive the program.
- The experience base and knowledge to successfully and credibly deal with complex situations that may be addressed exclusively over the phone and through documentation. In the inpatient setting, nurses are down the hall or physically in proximity for consultation and/or direct supervision. In home care, delegation, communication, coordination, and follow-up interventions are with team members who may be an hour away or even across state lines. This is why there is such an emphasis on continual quality improvement in home care, including the ongoing and systematic process of data review related to outcomes and other quality initiatives.
- Possession of an incredible attention to detail. This is necessary to support daily operations related to billing and documentation, especially related to outcome and assessment information set (OASIS) data collections. Because all of these components go hand in hand, they are equally important. A home health agency manager who does not have necessary documentation (read: coverage and medical necessity) to support the bills faces problems not only from a risk-management standpoint but also from the payer's viewpoint. The payer may view problems like this situation as overutilization, an area that may sometimes indicate abuse or even fraud. The documentation in billing and the clinical records must be correct for any audit trail (Marrelli, 2017).

The daily operations of most nursing units, whether in the acute care or alternative patient care sites, such as home care or hospice, are alike in many ways. The patients need to be cared for, following physician orders and utilizing competent, oriented team members who act within their individual practice guidelines. Home care operations are unique in that the practice setting for the clinicians is the patient's home, not an institution. The focus is, and always has been, on patient involvement and agreement on the plan of care. This setting for care changes the dynamic, as the nurse is a guest in someone's home and space. The sidebar goes into further detail on the daily operations.

DAILY OPERATIONS IN HOME CARE

Operationally, the home care manager must deal with the following issues:

- Orientation and training of competent home care clinicians (generalist—Medicare visit staff versus infusion, maternal-child, pediatrics, wound/ostomy/continence, and others)
- Maintaining personnel requirements that are not always synchronous with acute care requirements (e.g., education records of home health aides [12 hours per year, physical examinations, etc.])
- Assigning patients based on patient needs and geographic location
- Scheduling of team members in sometimes large and diverse settings (e.g., metropolitan areas, suburban and/or rural, multi-county, interstate)
- Facilitating team/case conferencing and team meetings for the Medicare Conditions of Participation (COPs)
- Coordinating care over a large geographic area and communicating with different vendors/providers of care
- Obtaining signatures on physician orders and on clinical records within specified time frames
- Addressing patient care records and security/confidentiality concerns (records taken out of the office to patients' homes—HIPAA compliance considerations)
- Managing patient care delivery models that meet patient needs and numerous regulatory and payment requirements
- Ensuring documentation meets requirements
- Supervising team members who are not visibly present in the office
- Handling with medical emergencies in homes and team members' "isolation" at those times
- Collaborating with appropriate disciplines over patient care–related progress
- Evaluating team member safety while driving to, and while in, patients' homes

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- Organizing administrative functions that encompass total patient length of stay:
  - Admission process—OASIS C-2 data collection, rights and responsibilities, etc.
  - Data entry of daily visits, supplies, and other billable services
  - Verification of insurance, billing information
  - Billing routines to Medicare and other third-party payers
  - Accounts receivable management
  - Computerization and financial management
  - Discharge of patients
  - Annual reports of total organizational functioning to governing body
- Addressing risk management issues (team member awareness of potentially volatile situations, etc.)

Summary

Knowledge of patient-centered care, shared governance, and professional practice models are essential as new nurse managers lead their teams in providing high-quality and cost-effective care to patients and families.

Understanding and using a patient classification system, together with a master staffing plan for the area, will help the new nurse manager to staff the area efficiently and effectively. There are always concerns about liability connected with staffing. Issues concerning credentialing are important to learn, especially the issue of continued, ongoing competency of the nursing team.

Mastering the ability to lead efficient and effective meetings is a priority, as is that of facilitating clinical conferences. Learning to prioritize duties and effectively manage time is a necessity for the nurse manager, whose work never seems to be done. Making rounds in the patient area assists in maintaining visibility as well as in accomplishing many other managerial tasks. Finally, internalizing accreditation standards helps the nurse manager in decision-making, which helps the area achieve and maintain quality nursing care.

The nurse manager should have a strong understanding of legal issues, regulatory requirements, and the increased level of responsibility for those under supervision. Nurse managers have a high level of accountability in these areas.

Thoughts for Consideration

1. Define the main purpose of the transaction rule.
2. Describe three sources of accepted standards of practice.
3. List the four components that must be involved to prove professional negligence.
4. Discuss the fine line of providing adequate information to obtain informed consent and overburdening the patient with too much information.
5. Explain the main purpose of (1) the privacy rule and (2) the security rule.

For Further Reading

- Agency for Healthcare Research and Quality, Clinical Guidelines and Recommendations, available at https://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/index.html
- "Assessing Progress on the Institute of Medicine Report 'The Future of Nursing'," Institute of Medicine, December 2015. Available at http://www.nationalacademies.org/hmd/~/media/Files/Report%20Files/2015/AssessingFON_releaseslides/Nursing-Report-in-brief.pdf
- *Handbook of Home Health Standards: Quality, Documentation, and Reimbursement,* by Tina M. Marrelli
- *Implementing the Evidence-Based Practice Competencies in Healthcare: A Practical Guide for Improving Quality, Safety, & Outcomes,* by Bernadette Mazurek Melnyk, Lynn Gallagher-Ford, and Ellen Fineout-Overholt
- *Nurses and the Law: A Guide to Principles and Applications,* 2nd Edition, by Nancy J. Brent
- *Nursing Avoiding Liability Bulletin and Blog,* available at http://www.cphins.com/category/nursing/
- "Nursing Care and Do Not Resuscitate (DNR) and Allow Natural Death (AND) Decisions," American Nurses Association Position Statement, available at http://www.nursingworld.org/dnrposition

- "The Business Case for Optimizing the Nursing Workforce," by Lillee Gelinas, available at https://www.americannursetoday.com/business-case-optimizing-nursing-workforce/
- "Transparency and Accountability in Nurse Staffing," by Sharon A. Morgan, available at https://www.americannursetoday.com/transparency-and-accountability-in-nurse-staffing/

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