AONE GUIDING PRINCIPLES

FOR THE ROLE OF THE NURSE EXECUTIVE IN PATIENT SAFETY

Introduction

The following toolkit was developed to provide resources to assist nurse leaders and their organizations in implementing the *AONE Guiding Principles for the Role of the Nurse Executive in Patient Safety*. The role of the nurse executive in patient safety is to help lead best practices and establish the right culture across multiple disciplines within the organization. The nurse leader must have the competencies necessary to design, coordinate and move forward patient safety principles and practices across the domains of governance, practice/patient care, education and research. This can only be accomplished in collaboration with the interdisciplinary team of health care academia, solution providers, policy makers and the community.

Lead Cultural Change

Transforming culture change from that of a silent, hierarchical structure of blame to an open, team-oriented culture will improve patient safety. Human factors researcher and author, James Reason (1998) contends that a safe culture is an informed culture. An informed culture is "one in which those who manage and operate the system have current knowledge about the human, technical, organizational and environmental factors that determine the safety of a system as a whole."

- Develop a safe culture that assures accountability and respects and values individual contributions and perspectives.
- Incorporate safety as a visible design element in the system as a shared leadership accountability at the most senior level.
- Provide the knowledge, tools and resources to prepare nurses to lead the safety agenda.
- Value and promote nurse managers and frontline nurses' leadership in creating the safety culture.
- Provide patient-centric care by partnering with the patient and family to share, understand and align perceptions and reality of the care process.

Methods to Lead Cultural Change

- Recognize and reward reporting of errors and near misses (just culture response to reporting).
- Increase executive leadership interactions with staff on patient safety issues.
- Enhance workforce knowledge about zero defects.
- Enhance skill set in communication of unanticipated outcomes.
- Increase the amount and quality of feedback to staff regarding changes made after incidents are reported.
- Ensure communication about, and understanding of, organization's critical policies and implications for failure to comply.
- Implement processes that are convenient for broad staff participation.
- Engage patients and families by creating a patient safety brochure that encourages them to be more involved with their care process by speaking up if something doesn't seem right or they don't understand what is happening.
- Identify a validated culture of safety survey instrument; monitor progress.
- Provide tools to assist managers and staff with the expectations for improvement.
- Report results throughout the organization with the goal of transparency.
- Create an audit/monitoring plan; report progress to the board, executive leadership team and throughout the organization.
- Create an annual patient safety award to recognize outstanding teamwork in making patient care safer. A safety culture assessment will provide a baseline and raise awareness throughout the organization. The Agency for Healthcare Research and Quality has designed a Survey on Patient Safety that will identify areas in need of improvement. A copy may be found at www.ahrq.gov.

Provide Shared Leadership

Shared leadership is when members of a group accept responsibility for the work and life of the group. The group functions more effectively when there is shared responsibility, rather than a hierarchical leadership model. Shared governance is the system that facilitates shared leadership. It creates a forum for collective wisdom by creating standards of practice, measuring the effectiveness of the decision and fostering an environment that empowers the group to continually improve its processes and practice.

- Move from hierarchical leadership models to one of shared interdependence.
- Understand best practices and research tools used to create shared governance models.
- Define the role of the nurse at the leadership table for patient safety.
- Gain the perspective of other senior leaders, such as the CFO and CEO, to effectively communicate a business case for safety initiatives. Integrate the business requirements of the organization with patient safety requirements.
- Actively participate in pay-for-performance initiatives to create a bridge between financial/business organizational issues and patient safety.

Methods to Provide Shared Leadership

- Integrate patient safety into every activity of the organization.
- Pay strict attention to detail.
- Keep the patient as the focus.
- Develop systems and processes that recognize the variations that exist and the potential for error.
- Surround yourself with like-minded professionals to move the cause forward.
- Create a design/model that fits your organization and one that embeds integrity and sustainability.
- Leverage the voice of the bedside nurse and continue to enhance competencies.
- Provide acknowledgement that each member of the shared leadership team may have their own mix of needs and wants, these needs and wants are essential to groups' healthy functioning. They provide some of the motivation, energy and glue for group life.

Build External Partnerships

External partnerships are essential for driving patient safety agendas. The nurse executives and the external partners stand to gain great benefits through collaboration. The collaboration involves the nurse leaders learning the latest best practices around managing people, developing processes and implementing solutions from various organizations; and the partnering organizations develop a greater appreciation and understanding of the problems a nurse executive is trying to overcome to improve patient safety.

- Drive the patient safety agenda through collaboration and partnerships.
- Reach out to academia, technology solution providers, communities, policy makers, regulatory agencies, state and federal agencies and professional organizations to advocate for nursing and patient safety.
- Proactively develop partnerships with academic institutions to drive effective curriculums that reflect working realities and include principles of safety.
- Create visible partnerships with the public around patient safety initiatives.
- Leverage the bedside nurse in the provider/technology partnership to enable ownership and effective implementations.
- Shape the external environment to support patient safety.

Methods to Build External Partnerships

- Improve external partnerships by defining the current relationship and identifying the gaps.
- Set goals/objectives for each type of relationship (Figure 1). Keep in mind that each relationship will add unique value to your knowledge portfolio.
- Map out what information you would like to gain from each relationship. This helps ensure your time is spent wisely and your relationship portfolio is well diversified.
- Use the set objectives to enable you to better understand how to use the information gained, leverage any synergies between the groups and determine if there are any additional types of relationships that you would like to form.
- Once your goals/objectives are set, select an organization and contact for each relationship type.

Figure 1: Sample Goals/Objectives by Organization for Building External Relationships

Partner	Objectives
Academia	• Develop best practices. • Drive effective curriculums that reflect working realities and include principles of safety. • Appoint joint facility to train nurses. • Align graduation nurses and workforce needs to mitigate shortages.
Technology solution provider	• Sponsor seminars and users groups to share new innovated practices. • Work together to understand the people, processes, and technology changes required for designing safe systems. • Work with bedside nurse to promote ownership and effective implementation of new technologies.
Communities	• Create visible partnerships with the public around patient safety inititatives.
Policy makers in health care regulatory agencies	• Define the issues and solutions to shape public policy.
State and federal agencies	• Monitor issues from standard-setting committees, comment when regulations are published, participate when possible. • Monitor issues and trends on patient safety topics. • Offer written comment and proposals and key legislation. • Provide written comment and testimony during public comment periods.
Professional organizations	• Join committees that help shape positions on key issues. • Participate in annual and local meetings to share your organization's best practices.
Patient and family	• Involve patient and family in process redesign and policy formation.

Develop Leadership Competencies

Leadership competencies around patient safety are intended to identify and establish skills common to nurses in executive practice. In order to assure that nurse leaders have the skills and knowledge to create a culture of safety, a Patient Safety Competency Model (Figure 2) specifically designed for the nurse leader was developed.

The model is designed to assure that the practice environments support exemplary, safe, high quality care of patients and families through effective nurse leadership. A knowledge base and skill set in the science of patient safety is a key competency for nurse leaders in today's health care environment. This model pulls together a comprehensive set of elements that nurse leaders must be knowledgeable in to assure cultures of safety in their practice environments and the ability to influence nursing school curriculum. A basic assumption is that the leader is able to maintain a competent workforce.

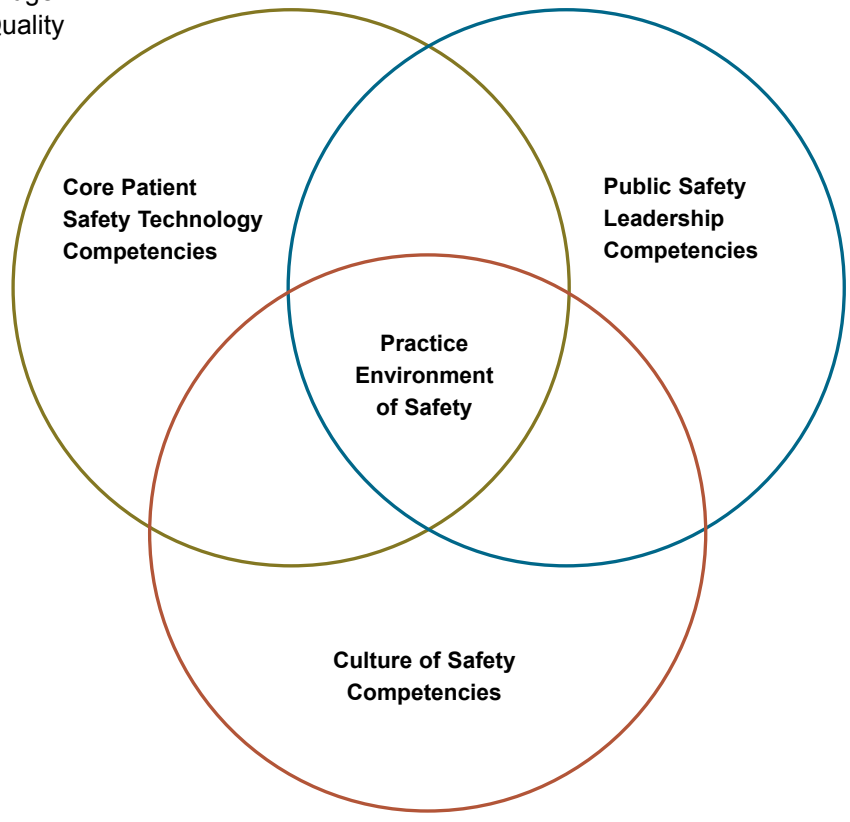
- Enhance and focus the patient safety skills of future nurse leaders.
- Identify the skill sets that are relevant to nursing leadership in patient safety.
- Leverage established skills and existing resources and tools such as the *AONE Nurse Executive Competencies,* the American Nurses Credentialing Center (ANCC) 14 Forces of Magnetism, the *Nurse Manager Skills Inventory*©, and the National Patient Safety Foundation's (NPSF) agenda for patient involvement, *Nothing About Me Without Me*.
- Develop, implement and evaluate additional tools through industry collaboration.
- Create unrelenting champions of patient safety.

Methods to Develop Leadership Competencies

Very specific knowledge areas have grown demonstrably in the past decade in the areas of human factors, error reporting, fair and just cultures, Lean, Six Sigma, High Reliability Organizations and many more. Three competency domains, patient safety leadership, core patient safety technology and culture of safety, were identified as essential to the development and implementation of a practice environment of safety.

Figure 2: Nurse Leader Patient Safety Competency Model

Core Patient Safety Technology	Culture of Safety	Public Safety Leadership
• Systems Process Management Process Improvement • Error Reporting Systems • Human Factors • Root Cause Analysis • Safety Rounding • Teaming • Risk Management • Error Mitigation FMEA • Error Recovery at Sharp Edge • Victims of Error Apology to patient/family Support staff at Sharp Edge • System Thinking and Quality Improvement Methods • Patient- and Family-Centered Care • Fair, Just, Respect Principles	• Practice Environment of Autonomy and Shared Decision Making • Accountability vs. Blame • Safety over Convenience Orientation • Resources • Supports • Communication • Shouldering the Burden of Improvement vs. External Blame	• Active and Disciplined Listening • Engagement and Inclusiveness • Vigilance for Error Identification • Integration of People and Tasks • Interdisciplinary Co-leadership and Collaboration • Action Orientation • The Art of Championing • Collaboration Practice Agreements • Team Leading and Participation • Importance of Top Down Leadership Culture of Safety



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