# Healthcare Trends and Changes in Nursing Professional Development

**T**HIS chapter provides an overview of healthcare trends that may influence the roles and responsibilities of nurses who lead staff development activities, whether as nursing professional development specialists (NPDSs) or unit-based clinical staff educators. As these trends represent only a sample of changes within the dynamic U.S. healthcare system, further exploration of additional trends is recommended. Nursing professional development (NPD) has also changed in response to these trends in health care. Strategies will be presented to guide nurses in assuming a leadership role and becoming prepared for evolving healthcare trends.

Approximately 2.8 million RNs and 690,000 licensed practical nurses (LPNs) were employed in the U.S. workforce from 2008 to 2010, the largest group of healthcare professionals in the country (U.S. Department of Health and Human Services [U.S. DHHS], 2013b). With this majority in mind, it is imperative that nurses are educated on the strategies that healthcare organizations have developed to manage and survive recent healthcare trends.

It is important for NPDSs and unit-based staff educators to understand how the healthcare delivery system functions, be cognizant of trends and issues that influence these healthcare organizations, and anticipate the future direction of the healthcare delivery system and healthcare organizations.

## Overview of Major Healthcare Trends

The implementation of legislative initiatives, such as diagnosis-related groups in the 1980s and managed care in the 1990s, resulted in financial constraints that affected the structure and function of healthcare organizations and the nurses they employed (Shi & Singh, 2015). During those decades, inpatient services shifted to less expensive treatments provided in outpatient care, long-term care, and homecare settings. Today, initiatives are being implemented to strengthen patient safety and improve the quality of healthcare reporting and services.

### The Patient Protection and Affordable Care Act

In 2010, a new healthcare reform era began with the Patient Protection and Affordable Care Act (ACA), a federal law designed to provide Americans with affordable health care despite preexisting health conditions (Shi & Singh, 2015; U.S. DHHS, 2014). Under the law, citizens were required (with few exceptions) to enroll in health insurance exchanges by 2013 or pur-

chase some form of public or private health insurance by January 1, 2014 (Shi & Singh, 2015). Those who failed to enroll were taxed (Shi & Singh, 2015). Although many individuals have identified benefits of ACA, others have cited its negative aspects. ACA offers a wealth of information regarding the direction of health care; however, three particular sections provide significant implications to the nursing profession.

Title III, Improving the Quality and Efficiency of Health Care, calls for a transformation of the U.S. healthcare delivery system to improve quality and safety outcomes (U.S. DHHS, 2015). It includes incentives for nurses and physicians who advance quality outcomes and reduce patient errors and harm. It also calls for more attention in designing new patient care models and ensuring quality care for seniors under Medicare.

Title V, Health Care Workforce, aims to increase the number of healthcare providers engaged in primary care and public health services through recruitment and retention strategies, such as scholarships and loan repayment programs for education and training (U.S. DHHS, 2015). It addresses the national nursing shortage by increasing the number of nurses and also increases the number of physicians, physician assistants, mental health workers, and dentists.

Title VI, Transparency and Program Integrity, promotes healthcare environments that embrace the transparent exchange and integrity of information, enabling the public to make informed healthcare decisions (U.S. DHHS, 2015). In particular, it promotes safe, quality care in long-term care settings through the use of employee background checks, continuous quality improvement initiatives, and ongoing staff safety education and training. Attention is paid to research focused on patient-centered outcomes and controlling waste, fraud, and abuse (U.S. DHHS, 2015).

## Institute of Medicine Recommendations

The Institute of Medicine (IOM) has played an instrumental role over the past two decades in response to the changes in the U.S. healthcare system, the state of healthcare delivery, and the need to prepare competent healthcare professionals. IOM has issued several landmark reports to guide the future of health care in America. *To Err Is Human: Building a Safer Health System* focused on patient safety and offered healthcare system strategies to decrease the number of preventable medical errors (IOM, 1999). *Crossing the Quality Chasm: A New Health System for the 21st Century* recommended a redesign of the U.S. healthcare system based on an analysis of the quality gap, expectations to support patient and clinician relationships, and ways to foster evidence-based practice (EBP) and stronger information systems (IOM, 2001). The six areas cited as needing improvements were safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity (Berwick, 2012).

In 2004, IOM issued *Keeping Patients Safe: Transforming the Work Environment of Nurses*, which recommended remedies to patient safety threats associated with the working environment. This report also offered an action plan on work issues, such as nurse staffing levels, work hours, and mandatory overtime.

From a collaboration with the Robert Wood Johnson Foundation (RWJF), IOM's 2010 landmark report *The Future of Nursing: Leading Change, Advancing Health* was an effort to "assess and respond to the need to transform the nursing profession" (p. xii) and prepare a nursing workforce suited to meet current and future healthcare changes. The report conveyed four key points (IOM, 2010, p. 4):

- Nurses should practice to the full extent of their education and training.
- Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression.

- Nurses should be full partners, with physicians and other healthcare professionals, in redesigning health care in the United States.
- Effective workforce planning and policy-making require better data collection and an improved information infrastructure.

Figure 1-1 outlines IOM's eight recommendations for preparing nurses for the future and overcoming barriers within work environments.

Consistent with its efforts toward promoting quality health care for Americans, IOM turned its attention to the growing number of cancer survivors and the current state of care available to them (IOM, 2013a). In *Improving the Quality of Cancer Care: Addressing the Challenges of an Aging Population*, IOM noted a substantial increase in the number of older adults being diagnosed with cancer during an era of healthcare workforce shortages (IOM, 2013b). In 2013, IOM published *Delivering High-Quality Cancer Care: Charting a New Course for a System in Crisis*, its comprehensive investigation of cancer care in the United States. IOM made recommendations essential to improving the current cancer care delivery system and quality patient outcomes (IOM, 2013a). Central to these changes, it proposed a conceptual framework of six elements aimed to improve the quality of care across the cancer continuum (IOM, 2013a, pp. 3–5):

- Engaged patients
- An adequately staffed, trained, and coordinated workforce
- Evidence-based cancer care
- A learning healthcare information technology (IT) system for cancer
- Translation of evidence into clinical practice, quality measurement, and performance improvement
- Accessible, affordable cancer care.

IOM's recommendations provide oncology nurses with opportunities to assume leadership roles in changing current and future cancer care services within their work settings (Becze, 2014; Ferrell, McCabe, & Levit, 2013). NPDSs involved in cancer care education should review these recommendations with nurses and develop proactive strategies to positively influence cancer care.

In addition to IOM's cancer care reports, oncology nurses and NPDSs need to understand the national accreditation standards for specialty services, such as those found in the American College of Surgeons Commission on Cancer's (ACS CoC's) *Cancer Program Standards 2012: Ensuring Patient-Centered Care*. According to these standards, "Oncology nursing care is provided by nurses with specialized knowledge and skills" (ACS CoC, 2012, p. 66). Oncology nursing education resources, such as courses available through the Oncology Nursing Society (ONS), are referenced as optimal means for preparing nurses caring for patients with can-

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**Figure 1-1. Institute of Medicine Recommendations on the Future of Nursing**

1. Remove scope-of-practice barriers.
2. Expand opportunities for nurses to lead and diffuse collaborative improvement efforts.
3. Implement nurse residency programs.
4. Increase the proportion of nurses with a baccalaureate degree to 80% by 2020.
5. Double the number of nurses with a doctorate by 2020.
6. Ensure that nurses engage in lifelong learning.
7. Prepare and enable nurses to lead change to advance health.
8. Build an infrastructure for the collection and analysis of interprofessional healthcare workforce data.

*Note.* Based on information from Institute of Medicine, 2010.

cer. Certification in oncology nursing within these organizations is not required but is highly encouraged (ACS CoC, 2012). The credentials and competencies of cancer care nurses must be evaluated on a yearly basis and recorded according to policy (ACS CoC, 2012). Specific criteria for measuring an organization's compliance with these standards are also outlined in the accreditation manual.

## Transforming Nursing Education

Another landmark report on the future of nursing, *Educating Nurses: A Call for Radical Transformation* (Benner, Sutphen, Leonard, & Day, 2010), called for a change in how nurses are prepared to meet current and future healthcare demands, claiming that nurses are under-educated to meet the complex challenges in clinical practice and academic settings and are unable to keep up with fast-paced changes in practice, resulting in an education–practice gap. Several recommendations for redesigning nursing education are provided in the report, calling for changes in teaching and learning practices and policy.

## Patient Safety in Practice and Education

In addition to IOM and ACA efforts to strengthen patient safety and the quality of healthcare reporting and services, other national groups have implemented related initiatives. The Joint Commission, an organization that accredits and certifies healthcare organizations, strives to improve health care for consumers through evaluation of quality and safety standards (Joint Commission, n.d.-a). Nearly two decades ago it created the Sentinel Event Policy, aimed to assist hospitals when they encounter an event that affects a patient (Joint Commission, n.d.-c). A *sentinel event* is a "safety event not primarily related to the natural course of the patient's illness or underlying condition that reaches a patient and results in any of the following: death, permanent harm, or severe temporary harm with an intervention required to sustain life" (Joint Commission, n.d.-c, para. 2).

In 2002, the Joint Commission initiated its National Patient Safety Goals (NPSGs), which focused on solving healthcare safety problems (Joint Commission, n.d.-b). These safety issues included several nursing responsibilities, such as safe medication administration, communication, clinical alarm safety, healthcare-associated infections, and patient identification. Although the Joint Commission identifies new safety priorities each year, prior NPSGs often remain as expectations for successful accreditation (Gorbunoff & Kummeth, 2014).

In an effort to prepare future nurses in meeting national quality and safety standards, the RWJF-funded Quality and Safety Education for Nurses (QSEN) Initiative established competencies expected of students enrolled in prelicensure RN and graduate nursing programs (QSEN Institute, 2012). Created in 2005, QSEN competencies align with those of IOM (2003) and comprise six qualities of knowledge, skills, and attitudes: patient-centered care, teamwork and collaboration, EBP, quality improvement, safety, and informatics (QSEN Institute, 2014). The QSEN Institute also provides teaching resources and ongoing faculty development programs.

## Current and Future Nursing Workforce

The nursing shortage (American Association of Colleges of Nursing [AACN], 2014b) has compounded current initiatives and will influence future ones. Although the recent reces-

sion led to a slight increase in RN employment within the U.S. (AACN, 2014b), a 2009 study projected that hospitals may expect a "shortfall of RNs developing around 2018 and growing to about 260,000 by 2025" (Buerhaus, Auerbach, & Staiger, 2009, p. w663) unless nursing schools are able to increase their capacity to produce nurses. More recent workforce reports predicted the shortage to continue into 2030, with the greatest need for nurses in the southern and western regions of the country (Juraschek, Zhang, Ranganathan, & Lin, 2012). An aging workforce is among the major reasons for the nursing shortage (Buerhaus et al., 2009; Juraschek et al., 2012). A similar shortage in qualified nursing faculty also has implications for healthcare organizations that need to fill vacant nursing positions, as well as nursing schools, which will need to limit student enrollment (AACN, 2014a). These workforce projections are alarming in an aging, diversifying, and growing U.S. population (U.S. Census Bureau, 2014).

National efforts have been made to increase the number of prepared RNs and the capacity of nursing schools. Attention has been paid to creating a nursing workforce that reflects the demographics of the U.S. population. Since 2008, the RWJF New Careers in Nursing program, a collaboration between RWJF and AACN, has awarded scholarships to underrepresented students who are enrolled in an accelerated nursing program (RWJF, n.d.). It also provides mentoring and leadership development.

## Trends in Healthcare Delivery

Healthcare organizations have responded to healthcare trends and managed care in a variety of ways. Unfortunately, some institutions were unable to maintain their financial viability and did not survive decades of economic turmoil. From 1990 to 2000, 208 rural hospitals (7.8% of national rural hospitals) and 296 urban hospitals (10.6% of national urban hospitals) were forced to close (U.S. DHHS, 2003). Many of these closures were attributed to a low census, mergers or relocations, and competition (U.S. DHHS, 2003). According to the American Hospital Association's (AHA's) annual survey of U.S. hospitals, similar shifts in hospital closures continue to occur with a decrease of 37 registered hospitals (5,723 down to 5,686) reported from 2012 to 2013 (AHA, 2014, 2015). Similar declines were noted among rural (1,980 down to 1,971) and urban (3,019 down to 3,003) community hospitals (AHA, 2014, 2015). More recent data from the North Carolina Rural Health Research Program (2015) indicated that 54 U.S rural hospitals have closed their doors between January 2010 and June 2015.

Shi and Singh (2015) reported that the U.S. healthcare delivery has been shifting its focus over the past two decades from individual health within an inpatient, acute care, and illness-oriented context to the health of a community, framed within an outpatient, primary care, and wellness perspective. Hospitals also are transitioning from being independent institutions with fragmented care and duplicated services to integrated systems with managed care and a continuum of services (Shi & Singh, 2015). Health promotion combined with cost reduction has been the impetus for these healthcare changes (Shi & Singh, 2015).

Insightful healthcare organizations have survived these restrictions by reexamining the ways they have internally functioned. These organizations constantly strive to develop cost-effective means to maintain or attain quality and safe patient care outcomes. Numerous changes have occurred within healthcare organizations, but six come to the forefront: financial streamlining, organizational integration and realignment, new models of patient care delivery, work redesign and role changes, safety and quality performance indicators, and health IT.

## Financial Streamlining

Past managed care and healthcare reimbursement changes forced many healthcare administrators to review their existing financial policies and procedures. Managers who dealt with patient care services and clinical divisions, such as nursing, were asked to streamline their operating budgets, control unnecessary expenses, seek untapped sources of revenue, and determine return on investments. Major budgetary expenditures, such as salary and other personnel costs associated with healthcare workers, were targeted as expenses that needed to be controlled. Departments were examined based on operating costs and ability to generate additional revenue for the organization.

In addition to reducing direct labor costs, these reimbursement changes forced organizations to closely examine expenses related to patient care services, consumer services, and the approach used to deliver these services. Many low-risk surgeries and treatments and invasive diagnostic procedures that were traditionally inpatient practices were modified using a more cost-effective outpatient approach (Shi & Singh, 2015). In fact, outpatient surgeries increased by nearly 50% from 1980 to 2010 (Shi & Singh, 2015; U.S. DHHS, 2013a).

This shift in healthcare services resulted in a different inpatient profile. For example, individuals admitted to acute care agencies (hospitals) possessed higher acuity levels than in past years, requiring skilled and intensive nursing care. After a shortened length of stay in the hospital, some patients were discharged to other healthcare agencies that offered subacute, intermediate, or extended nursing care. Healthcare workers employed in these transitional units provided much of the nursing care previously performed in the acute care environment. In fact, some organizations added new clinical services, such as transition units, within their own systems to help patients change from acute care to a home setting. Other patients were discharged with or without homecare services. Attention was paid to reducing patient readmission shortly following discharge.

## Organizational Integration and Realignment

Beginning in the late 1990s, hospitals underwent organizational integration in an effort to remain viable by becoming cost-effective and diversifying operations with new services or products (Shi & Singh, 2015). Integration strategies included acquisitions, mergers, alliances, joint ventures, and virtual networks (Shi & Singh, 2015).

Many chief operating officers dealt with these financial constraints by focusing on the internal structure of their organizations and the allocation of resources. Some completely reorganized or realigned their structures, whereas others chose to implement minor changes in their existing organizations. Low utilization rates and competition over decades influenced organizational downsizing or rightsizing, often resulting in major changes in or elimination of divisions and departments (U.S. DHHS, 2003). In some instances, services, such as laundry, dietary, and education, were outsourced or contracted through external companies. Many healthcare organizations closed patient units and reduced their number of beds. Some departments that were non–revenue generating or advisory in nature, such as staff education, often faced negative consequences.

Healthcare organizations, confronted by the influence of managed care, focused their efforts on securing their share of the healthcare market. Many agencies diversified services in an attempt to obtain more patients or clients (Shi & Singh, 2015). In an effort to compete with other healthcare organizations for customers, some hospitals expanded or shifted ser-

vices from inpatient admissions to include outpatient, subacute care, homecare, long-term care, ambulatory care, and community-based efforts.

## New Models of Patient Care Delivery

Related to financial and organizational reforms, new models in organizing and delivering care have emerged in an effort to improve primary healthcare services for Americans in settings such as physician offices and community health centers (Agency for Healthcare Research and Quality [AHRQ], n.d.-b). According to AHRQ and the National Committee for Quality Assurance (NCQA), the patient-centered medical home (PCMH) should be viewed as a "model of the organization of primary care that delivers the core functions of primary health care" (AHRQ, n.d.-a, para. 1). In a PCMH, the primary care physician leads a collaborative team of healthcare professionals in providing access to coordinated care services based on the needs and preferences of patients and their families (Caudill, Lofgren, Jennings, & Karpf, 2011).

A PCMH also aims to advance how consumers and healthcare providers perceive their healthcare experience (NCQA, n.d.). A PCMH comprises five elements: comprehensive care, patient-centered (relationship-based) care, coordinated care, accessible services, and quality and safety (AHRQ, n.d.-a). Practices that choose to become PCMHs can apply for NCQA Recognition (NCQA, n.d.).

Similar PCMH models have been created in clinical specialty practices. For example, the Centers for Medicare and Medicaid Services (CMS) (2014c) recently developed an Oncology Care Model (OCM) to address the current state of cancer care in the United States because of the increasing number of older adults diagnosed with or surviving cancer. OCM is a cancer payment model that offers financial incentives to physician practices that increase the quality and coordination of the cancer care services they provide while also decreasing costs. Oncology practices that deliver chemotherapy enter into payment arrangements that include financial and performance accountability for episodes of care (CMS, 2014c) and are evaluated on more than 30 quality measures (Clark, 2015). Practices are expected to offer 24-hour outpatient clinics where patients can receive treatment for their chemotherapy-associated symptoms rather than seek such care at hospital-based emergency departments (Clark, 2015). Scheduled to begin in 2016, OCM is intended to decrease both hospital and pharmacy costs (Clark, 2015).

## Work Redesign and Role Changes

Efforts to restructure and downsize in healthcare agencies also compelled healthcare administrators to examine how work was being accomplished. Managers were encouraged to redesign work in a manner that was cost-saving, efficient, and effective. Frequently, all but essential financial and human resources were trimmed from budgets. Employees in these departments were encouraged to rethink their responsibilities and develop innovative ways to perform their jobs. They were asked to "work smarter, not harder" and "do more with less."

New paradigms or models that resulted from these work redesigns often changed the roles and responsibilities previously assumed by employees of these healthcare organizations. Although some workers could easily adjust to their new roles by making minor modifications in their daily activities, others needed to be cross-trained or retrained to gain the knowledge and skills required to function in their new roles.

## Safety and Quality Performance Indicators

In concert with cost-effectiveness and efficiency, healthcare organizations focused their efforts on measuring and managing outcomes related to healthcare services, such as patient care (Shi & Singh, 2015). Healthcare workers were challenged on a daily basis to provide quality patient care with fewer resources. Managers were encouraged to make decisions using data-driven outcome measurements (Shi & Singh, 2015). Hospitals focused attention on landmark reports, performance indicators related to patient safety, and ACA-mandated improvements in safety, quality monitoring, and reporting (U.S. DHHS, 2015).

Existing systemwide quality control programs that focused on quality and effectiveness of clinical services were enhanced within healthcare organizations (Shi & Singh, 2015). Managers were encouraged to improve quality and safety goals and reduce associated costs. Outcomes management initiatives, referred to as *total quality management* (TQM), gained popularity (Shi & Singh, 2015). Because the primary focus of TQM is continuous improvement in all organizational processes, managers and employees were encouraged to improve their performance daily.

For example, suppose the nursing staff on your unit wanted to improve their performance related to patient admissions. You would begin by breaking down your existing admissions procedure into its smallest components. While reviewing this process, you decide what steps are essential, who should perform them, and how they can be implemented more efficiently and effectively. During this process, you discover your staff repeated many steps without reason, or perhaps you uncover omissions in other departments that prevented your agency from reaching the best outcome. While working on this problem, you decide to investigate how other healthcare organizations excel in the process, referred to as *benchmarking* (Shi & Singh, 2015). This information is used to refine the admission procedures at your workplace.

The significance of cost-effective, quality patient care has led to the development and implementation of patient-centered and outcome-based tools, such as critical pathways and clinical practice guidelines (Shi & Singh, 2015). These items, developed with input from nurses, are useful in guiding practice and reaching clinical outcomes within prescribed time frames. Innovative patient care delivery models, such as case management, evolved and emphasized meeting patient outcomes within specific time parameters (Shi & Singh, 2015).

Reimbursement for patient care services is negatively affected if a hospital does not adhere to national quality performance standards. Since 2008, CMS has stopped reimbursing to hospitals that experience preventable hospital-acquired conditions (e.g., stage III and IV pressure ulcers, falls and trauma, blood incompatibility) (CMS, 2014a). CMS also includes patient situations referred to as *never events*, such as surgery conducted on the wrong body part, an infant discharged to the wrong individual, and death or disability associated with a medication error (CMS, 2014b).

In an effort to gain national recognition for nursing excellence, some healthcare organizations have sought status in the American Nurses Credentialing Center (ANCC) Magnet Recognition Program®. This program, developed in 1994, is based on national standards of nursing practice and quality indicators and recognizes healthcare organizations that support professional nursing practice in their settings and offer excellent nursing care (ANCC, 2014).

## Advancing Information Technology

Hospitals are expected to advance IT initiatives that affect healthcare providers, consumers, and others who engage in healthcare delivery services. To support and expedite this goal, hos-

pitals receive financial incentives to facilitate the adoption of electronic health records (EHRs) within their organizations (Shi & Singh, 2015). These enticements were enabled under the Health Information Technology for Economic and Clinical Health Act in 2009.

In addition to implementing EHRs, Medicare and Medicaid also offer incentives if hospitals demonstrate meaningful use of health IT (Centers for Disease Control and Prevention [CDC], 2012), particularly in quality, safety, efficiency, reduction of health disparities, patient engagement, care coordination, and security of health information (Halamka, 2010; Shi & Singh, 2015). Healthcare organizations are penalized financially if they do not comply with meaningful use expectations (DesRoches, Worzala, & Bates, 2013).

Such IT advances are expected to facilitate daily operations of healthcare organizations and foster information sharing among hospitals for continuity of patient care. Consumer portals offer patients the opportunity to communicate with their clinicians, access health resources and information, and review results of tests and procedures. These advances enable consumers to be active participants in their own care (Shi & Singh, 2015). Further IT advances are still needed, such as comprehensive applications used by providers to manage patient healthcare needs (Conn, 2013).

The use of health-related technology by healthcare providers and consumers has been steadily increasing, as devices and applications used by both groups are becoming increasingly similar (Conn, 2013). Some consumers access their healthcare information from electronic sources, such as the Internet, social media, mobile applications, and patient or survivor portals.

Although healthcare organizations have developed patient portals in response to the meaningful use of health IT, Whitehurst (2014) advised that these organizations rethink their approach and create a comprehensive communication plan to engage patients and consider patient preferences. He offered several suggestions to providers as they revise their technology plan: assess the current state of patient communication, identify the communication needs of specific populations, respect patient preferences, experiment with different methods and tools, be flexible and aware of new technology, and strategically consider the message.

Justice (2014) described several technological sources that chronic cancer survivors can access to stay informed about their healthcare needs and any evolving treatment options. These resources include disease-specific websites, such as the National Cancer Institute (www.cancer .gov); Facebook groups that focus on issues such as myeloproliferative neoplasms; and patient opinion leaders sponsored on social media channels. Justice (2014) also emphasized the value of social media in empowering patients with cancer in managing and understanding their chronic cancer care needs.

Researchers have investigated the influence of technology use on patient outcomes. Gnagnarella et al. (2015) conducted a randomized six-month intervention with social media that aimed to increase the knowledge of healthy eating habits among cancer survivors. Although knowledge levels increased in both the treatment and control groups with no statistically significant differences, studies such as this provide researchers with insight into designing intervention studies to measure patient outcomes related to technology.

Given the technological advances that provide direct access to consumers, patients may find themselves being recipients of direct-to-consumer advertising from businesses, such as pharmaceutical companies (Pharmaceutical Research and Manufacturers of America [PhRMA], 2013). These businesses promote services or products, such as information on diseases and current treatments, directly to consumers (e.g., print advertisements, television spots or commercials, radio spots or commercials) rather than through traditional advertising avenues (e.g., through communication with healthcare providers). PhRMA (2008) has published guiding principles for companies to follow when implementing direct-to-consumer advertisements about prescription medications.

# Responding to Changes in Health Care

NPD has also undergone major changes over the past two decades. It was presented as a clinical practice specialty in 2010 by the American Nurses Association (ANA) and the National Nursing Staff Development Organization (NNSDO, now called the Association for Nursing Professional Development [ANPD]) in their publication *Nursing Professional Development: Scope and Standards of Practice* (ANA & NNSDO, 2010). This document presented a system-based NPDS model with inputs, throughputs, and outputs that reflected a major expansion, with changes in the roles, responsibilities, and clinical practices in what was previously known as nursing staff development (ANA, 1992, 1994, 2000, 2015).

Beginning in the 1990s, the restructuring of hospitals brought changes in the structure and function of NPD departments and nurse educators (Lockhart, 2004). These divisions, previously referred to as nursing staff development departments, nursing education and research departments, or NPD departments, were downsized, restructured, or eliminated. Changes also included the redesign of departmental priorities and the shifting and expanding of educator roles (Lockhart, 2004). Whereas a department's core functions were often retained by nurse educators who remained in NPD departments, other services needed to be decentralized and assigned to other nurses, often clinical RNs who worked on patient care units. Some professional development responsibilities were shifted to other nurses within the organization. As the roles assumed by staff development educators changed, so did those of unit-based nurses, as their responsibilities expanded to include direct patient care activities, management duties, and staff education.

Structures were created to facilitate communication between centralized personnel and unit representatives. Shared governance structures provided this opportunity through education councils. Clinical instructors were available to advise and mentor the nurses. Some unit-based nurses mentored and cross-trained RNs who were relocated to different clinical units. Because of their expertise, many unit-based nurses planned and implemented orientation, in-service programs, and competency testing on their units.

Gantz et al. (2012) advised nurse leaders to develop a more global perspective on health systems and workforce issues to gain insight on the best practices of competency development, quality improvement, and financial constraints.

While gaining a broader perspective of health care, it is important that you understand your professional nursing responsibilities. Especially vital is the leadership role you assume as an NPDS in strategically positioning and preparing your team to accomplish organizational and professional goals. The following sections of this chapter will highlight some strategies to consider as you assume a leadership role within your organization, whether it be as an NPDS or unit-based staff educator. In addition to focusing on leadership skills expected of you in the NPDS role, you may also investigate those skills outlined in specialty nursing organizations, such as the Oncology Nursing Society Leadership Competencies (ONS, 2012). These competencies will be discussed further in Chapter 2.

## Take Responsibility for Developing Your Competencies

NPDSs need to assume responsibility for developing personal and professional competencies. Begin by reviewing *Nursing Professional Development: Scope and Standards of Practice* (ANA & NNSDO, 2010) and compare these expected competencies with the duties listed in your job description. Discuss any discrepancies between the two sources with your manager

and seek clarification as needed. Network with colleagues in professional organizations related to your role, such as ANPD.

Next, conduct a self-inventory of the knowledge, skills, and attitudes expected in your professional role and determine any new skills that you will need to develop. For example, you may need to strengthen your skills in information and educational technology, EBP, or writing for publication. If you are having issues in educational technology, you are not alone. A survey of more than 1,300 ANPD members revealed that educational technology was underused in practice, citing a need for NPDSs to "assume responsibility for personal competence" (Harper, Durkin, Orthoefer, Powers, & Tassinari, 2014, p. 247) related to technology.

As you conduct your assessment, heed the recommendations made in IOM's *The Future of Nursing: Leading Change, Advancing Health* (IOM, 2010). If appropriate, consider pursuing a PhD or DNP and seeking additional learning activities to develop leadership competencies, manage change, and support staff.

Seek experienced NPDSs who can serve as mentors in your professional development. These mentors may be local or accessed through professional organizations.

## Assume a Leadership Role Within Your Organization and Profession

Leadership is among the core competencies of an NPDS and encompasses a variety of behaviors, from serving as a change agent and advocate of NPD offerings to being an ethical decision-maker and problem-solver (ANA & NNSDO, 2010). In fact, leadership comprises the largest portion (24%) of the 2014 test content outline designed for NPD board certification (ANCC, 2013). More specifically, the leadership content focuses on topics such as "organizational principles, concepts, and structures; leadership principles and practice; the workplace environment; professional development; and managing resources" (ANCC, 2013, pp. 2–3). Gaining an understanding of these leadership priorities can help you focus your personal development needs and identify appropriate leadership opportunities within your healthcare organization.

Westphal and McNeil (2014) emphasized the important role that nurses who are engaged in continuing education can play by serving in a boardroom. The authors identified nine competencies essential for nurses to be effective in this setting: open communication, planning, active engagement, collaboration, decision-making skills, financial stewardship, organizational skills, advocacy, and visionary skills.

IOM recommendations can guide you in developing a competent staff of nurses and other healthcare professionals that are able to provide safe and quality patient care, lead change, and advance health in your organization. NPDSs are responsible for creating a learning environment that welcomes innovation and supports lifelong learning and continuing competence. NPDSs need to help nurses understand trends, national expectations, and healthcare changes, which will develop them in new roles that align with the current and future directions of healthcare delivery.

## Align Priorities With Evidence-Based Sources

*Nursing Professional Development: Scope and Standards of Practice* (ANA & NNSDO, 2010) details the responsibilities that NPDSs and unit-based educators are expected to assume in their roles. Understanding the mission and goals of your healthcare organization as they correspond to recent and future healthcare trends can help you develop and prioritize goals for the NPD department and educators in alignment with the organization and various evidence-based sources.

The beginning of this chapter described several sources of evidence that NPDSs can use to address educational priorities. As an NPDS, remember that your ultimate goal is the "acquisition of knowledge, skills, and attitudes that support safety and contribute to the protection of the public and provision of quality care" (ANA & NNSDO, 2010, p. 7). Given this charge, various sources of evidence exist to guide you in determining your educational priorities. Especially valuable are the national regulations and standards for quality care and patient safety previously mentioned in this chapter.

For example, NPDSs can use the Joint Commission's sentinel events and NPSGs (Joint Commission, n.d.-b, n.d.-c) and CMS's preventable hospital-acquired conditions and never events (CMS, 2014a, 2014b) to focus educational activities on helping nurses understand these issues, prevent and report incidents, and gain vital competencies. In addition, these sources can help NPDSs and staff educators in conducting a gap analysis to identify essential continuing education programs and support practice initiatives, such as patient hand-off (change-of-shift) reporting; Situation, Background, Assessment, and Recommendation (SBAR) techniques for communication (Narayan, 2013); the use of rapid response teams; and root cause analysis (Connelly, 2012). Also, the "meaningful use" expectation for hospitals provides the rationale for staff education and learning using information technology such as EHRs and other portals. Finally, IOM (2010) recommendations provide support and future direction (see Figure 1-1) for nursing regarding lifelong learning and continuing competence, leadership development, residency programs, continuing education, and practice at the highest level.

## Focus on Cost-Effective Results-Oriented Outcomes

Given these educational priorities, you are expected to provide educational activities that lead to "cost-effective, results-oriented outcomes" (Harper et al., 2014, p. 247). Although it is expected that you deliver the throughputs described in the NPDS practice model (ANA & NNSDO, 2010), it is also important that you "evaluate the benefits in relation to costs when both are expressed in dollar terms" (Shi & Singh, 2015, p. 577). Given the current cost-conscience healthcare environment, limited resources, and multiple work priorities, it is important for NPDSs to calculate the return on investment of their professional development efforts and communicate the value of their department and role (Bjørk, Tørstad, Hansen, & Samdal, 2009).

To manage cost-effective, results-oriented outcomes, you need to be familiar with quality improvement, evidence-based projects, and research (see Chapter 12). It is also important to understand the sources of data within an organization and how to collect, manage, analyze, and interpret these data.

NPDSs and staff educators should be able to disseminate the results of their efforts (ANA & NNSDO, 2010). In addition to producing an executive summary of efforts to a manager or other stakeholders within an organization, it is important to share educational efforts through peer-reviewed journal articles and professional oral presentations and posters. This responsibility may require the development of new writing and presentation skills (see Chapter 9).

## Anticipate Future Directions and Opportunities for Improvement

Keeping abreast of trends and issues that affect healthcare systems needs to be a priority for NPDSs and unit-based staff educators. Understanding these changes and their potential influence on an employer can help you anticipate the future directions that the healthcare organization needs to take and help position the NPD department or NPD role to support these new initiatives.

For example, you can identify new opportunities to improve educational processes in providing safe, quality patient care. Understanding changes in the preparation of future nurses can help you anticipate changes in how your NPD department will orient and prepare newly hired nurses. A proactive approach can be taken to anticipate and manage potential barriers or threats. Although anticipating change within a dynamic healthcare environment may pose a challenge, it can offer you time to develop new skills and competencies in your nursing staff. To lead change, it is vital that nurses engage in lifelong learning opportunities.

Although predicting the future of health care is a tremendous challenge, Shi and Singh (2015) identified eight forces of future change: social and demographic, political, economic, technological, informational, ecological, global, and anthro-cultural (Shi & Singh, 2015). While the authors advised healthcare leaders to use these forces to guide their strategic planning efforts (Shi & Singh, 2015), gaining insight into these forces may also offer benefits for NPDSs and staff educators.

## Summary

Recent healthcare trends have resulted in the restructuring of healthcare organizations. Major changes have also occurred in the scope and standards of NPD. These alterations have resulted in multiple role adjustments for nurses employed in clinical practice settings, such as professional development and unit-based education. Changes in both organizations and NPD departments have also affected the roles and responsibilities of clinical staff nurses. NPDSs and unit-based clinical nurse educators need to take a proactive approach and assume these responsibilities, acquiring the knowledge, skills, and attitudes needed to function effectively in a vital new role.

## Helpful Websites

- Association for Nursing Professional Development: www.anpd.org
- Centers for Disease Control and Prevention—Meaningful Use: www.cdc.gov/ehrmeaningfuluse
- Centers for Medicare and Medicaid Services—Hospital-Acquired Infections: www.cms .gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Hospital-Acquired _Conditions.html
- Centers for Medicare and Medicaid Services—Never Events: www.cms.gov/SMDL/down loads/SMD073108.pdf
- Joint Commission: www.jointcommission.org
- Quality and Safety Education for Nurses Institute—QSEN Competencies: http://qsen.org/ competencies

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