

Defining and Assigning Accountability for Quality Care and Patient Safety

Christine Goeschel, ScD, RN

The prevalence of avoidable patient harm and preventable patient death in U.S. hospitals is widely acknowledged, yet legal and regulatory efforts to safeguard the public have had limited effect. Systems theory suggests that variations in practice and organizational deficiencies often result from the interdependencies and bidirectional effects of the parts on the whole. In health-care delivery, where many individuals and systems influence outcomes, a conundrum exists regarding how to assign accountability for preventable harm. When it is assigned, the question becomes how to administer sanctions with fairness to patients and families, clinicians involved in the error, and the institutions where the error occurs. This article discusses the regulatory challenge of defining accountability for quality and patient safety, suggests perspectives regulators should consider in balancing competing interests, and challenges regulators to lead the development of principles for team-based accountability.

Learning Objectives

- Describe how accountability relates to patient safety and quality.
- Identify at least two types of accountability.
- Define systems theory and systems thinking.

The landmark 1999 Institute of Medicine (IOM) report, *To Err is Human*, estimated that errors of commission cause nearly 100,000 needless deaths a year in hospitals (Institute of Medicine, 1999). Studies by RAND suggested that errors of omission may account for even greater morbidity and mortality (McGlynn et al., 2003). In the wake of these reports, consumers embraced patient safety as a right and evidence-based quality of care as an expectation. Organizations invested heavily in efforts to improve the health-care delivery system (Berwick & Leape, 1999). Unfortunately, little has improved. Measures of patient safety and access to care have actually gotten worse, and public trust of hospitals and health-care professionals continues to erode (Agency for Healthcare Research and Quality, 2009; Consumers Union, 2009; Wachter, 2010).

Accountability and Systems Theory

Systems theory holds that one cannot understand variations in practice and organizational deficiencies in isolation. One must recognize the interdependencies, linkages, and bidirectional effect of the parts on the whole and understand the whole within the context of the larger environment (Reason, 2005; Vincent, 2004; Weick & Sutcliffe, 2006). However, a limited understanding of this concept has led to the widespread belief that individuals are rarely responsible for anything but the most egregious errors

because system factors contribute to many mistakes. Moreover, administrators receive accolades for initiating improvement programs, even when they do not rigorously measure outcomes and cannot demonstrate improved care (Jha & Epstein, 2010; Rothberg, Morsi, Benjamin, Pekow, & Lindenauer, 2008). See Table 1 for how one might apply systems theory and thinking to accountability for medication errors.

Policymakers, however, are growing impatient with the lack of measurable progress (Arrow et al., 2009; Murray & Frenk, 2010). Thus, regulatory interventions to address quality and safety are increasingly common. Potential levers for increasing accountability include a payment policy tied to public reporting of quality and safety metrics, accreditation standards and goals for quality and patient-safety performance, and clinical licensure that requires accountability for evidence-based care (Abelson, 2007; Centers for Medicare & Medicaid Services, 2010). Yet, a conundrum exists regarding how to assign accountability for preventable harm and how to administer sanctions that are fair to patients, the clinicians involved in the errors, and the institutions where the errors occur.

This article discusses the regulatory challenge of defining accountability for quality and patient safety and explores its value to the profession, policymakers, and patients.

Regulatory Challenges

Regulators of nursing practice face unprecedented challenges (Skar, 2010). The complexities of an aging workforce, the political call to create high-reliability health-care organizations, and the dramatic changes in care delivery create a regulatory landscape that is dynamic and risky.

Regulatory bodies are responsible for keeping patients safe, in part by licensing caregivers who have the knowledge and skills to understand their role and perform it competently. Meeting that responsibility, however, involves a keen understanding of the broadest scopes of health-care regulation and practice (Lucero, Lake, & Aiken, 2010). Many synergistic influences can make care delivery more difficult and regulation increasingly ambiguous. These influences include the explosion of information technology and biotherapies, a rapidly aging patient population, and hospital payment tied to quality and patient-safety performance measures.

Administering justice via the regulatory system assumes that clear delineations of right versus wrong exist and that accountability for actions is attributable and beyond dispute (Dekker, 2007). However, ambiguity about what constitutes quality and patient safety is ubiquitous, and accountability is elusive. Failures in teamwork and communication often contribute to preventable harm—for example, when persons see a problem but do not speak up or when they speak up but are ignored (Pronovost, Miller, & Wachter, 2006; Wachter & Pronovost, 2009).

To stabilize the system, regulators must create safe opportunities for open dialogue, establish working relationships with regulators from other health-care disciplines (particularly medicine and pharmacy), and explore novel cross-discipline models for team accountability.

Accountability in Health Care

“At its most general, accountability is about individuals who are responsible for a set of activities and for explaining or answering for their actions” (Emanuel & Emanuel, 1996). Cross-discipline understanding of the unique histories of nursing and medicine offers a foundation for the concept of team-based accountability for quality of care.

Evolution of Medical Practice

The Social Transformation of American Medicine (Starr, 1982) describes the evolution of medical practice from a guild society where medicine was self-taught, medical care and medicine were marketplace commodities, and respect was based on individual skill, not discipline-based expectations. Thanks to advances in science and technology as well as social changes from the 1920s to 1970s, core educational curricula, licensure regulations, and uniform standards of medical practice emerged (Emanuel & Emanuel, 1996). Medicine became an esteemed profession that embodied art and science, and professional accountability for medical practice became the norm.

As the scientific basis of medical practice grew, acceptance of the art diminished. Professional tension escalated as evidence-based medicine threatened to restrict autonomy and hold the physician accountable for providing care inconsistent with his or her preference. By the 1980s, the growth of diagnostic and

TABLE 1

Systems Theory, Systems Thinking, and Accountability

Theories provide a set of interrelated concepts and principles that are generalizable. *Systems theory*, simply put, focuses on relationships and changes caused by interactions among all the factors in a system. *Systems thinking* is an approach to problem solving that is rooted in systems theory and thereby views problems from the perspective of interrelationships, factors, and microsystems in an overall system.

Accountability for medication errors may provide a useful example of how to apply systems thinking. Medication errors may take many forms: wrong patient, wrong drug, wrong dose, wrong route, or wrong time. The causes that contribute to the error will also vary. Systems thinking requires that assigning accountability goes beyond blaming the nurse who administered the medication, the physician who wrote an incorrect order, or the pharmacist who prepared the medication. Individual competency may be a factor in the error, but we must also look at system factors that allowed the error to occur.

treatment options made care and accountability more complex. Evidence-based care became the baseline for medical treatment, and the art (based on knowledge of individual patient biology and values and tacit knowledge from years of clinical practice) allowed the physician to develop an individualized care plan.

This increased medical accountability brought with it higher expectations for supporting disciplines—particularly nursing and pharmacy—to question the physician if ordered treatments seemed inconsistent with organizational policy, clinical evidence, or patient preference. By the 1990s, patients, payers, and policymakers began wielding more authority in health-care decision making, though an understanding of their influence is limited. No wonder many physicians are uncertain of their accountabilities, many medical regulatory bodies struggle with accountability versus justice, and the public, patients, and policymakers are confused about who deserves blame when things go wrong.

Evolution of Nursing Practice

Nursing’s evolution has been more recent and more uneven than that of medicine. During the Crimean War, Florence Nightingale set the image of nurses as angels of mercy, and the role of nurses as patient advocates is still essential. However, the roles of the nurse as scientist, educator, clinician, and manager are now also irrefutably intertwined with nursing accountability to the patient, to the profession, and to the public. The NCLEX was a critical step toward uniform nursing standards, yet state and regional variation in the evolutionary path of nursing influences both licensing regulations and the capacity for national norms related to accountability. The same evolution of science and technology

that transformed medicine changed the context of care delivery for nurses. What does this mean for nursing regulators who are responsible for keeping the public safe?

In the premier issue of the *Journal of Nursing Regulation*, Kathy Apple, MS, RN, FAAN, Chief Executive Officer for the National Council of State Boards of Nursing, describes nursing regulation as “all about setting the minimal standards for public protection and enforcing them by law” (Saver, 2010). If that is true, nursing accountability for quality and patient safety should be linked to those minimal standards; taught in nursing curricula; tested in nursing licensure exams; understood by the public at large, patients, and policymakers; and enforceable in the courts.

Setting minimal standards for public protection is not an easy task. Nurse practice acts vary from state to state; nursing curricula are not standardized; and licensure exams test only the most basic knowledge. Moreover, standard metrics for quality and patient safety are rare, and our understanding of health-care delivery is a nascent science. Thus, even minimal standards are hard to define.

Nursing programs, in which clinical time is limited and well mentored, are hard-pressed to prepare nurses for life in the trenches, where soon after graduation many will be making life-and-death decisions. Couple this with the lack of a uniform requirement for continuing nursing education and the exponential pace of change in pharmacotherapeutics, diagnostic technologies, and information technologies, and the current concerns about accountability versus blame are not surprising.

Shared Accountability: Minimizing Ambiguity

Deciphering accountability and determining when individuals and systems are culpable are challenges. None of us—nurses, physicians, nor administrators—learned our craft working in collaborative teams, but today the public, policymakers, and payers expect us to practice as a synchronized whole. It is time to join forces and develop principles for health-care accountability that serve the public, clinicians, and the system.

A reciprocating matrix model of accountability in health care, first described in the literature 15 years ago, may be useful for understanding and acting on accountability for quality and safety (Emanuel & Emanuel, 1996). The components of accountability—determining who is accountable for what and how and by what procedures are they held accountable—provide a foundation for exploring various perspectives. (See Figure 1.) A contemporary framework provides a method for systematically considering the dimensions of clinical, administrative, economic, and political accountability.

Accountability Models

The use of regulation to impose accountability for quality of care requires that well-defined quality metrics exist, that caregivers and organizations know the expectations regarding quality performance, penalties for violations, and effective enforcement mechanisms are in place. Each of these items warrants thorough review by the regulatory board seeking to establish nurse accountability for quality and patient safety (Dekker, 2002).

This basic regulatory perspective on accountability is necessary but not always enough for the board of nursing to make well-informed decisions. Large bodies of literature address clinical, organizational, economic, and political accountabilities, and each warrants separate exploration by the interested reader.

Clinical Accountability

Historically, boards of medicine and nursing and the courts addressed individual accountability based on the limits of licensure. However, in the era of health reform, the scopes of nursing and medical practice sometimes appear to overlap. When professional and domain-specific clinical standards are in place, accountability is relatively easy to assign. However, as clinicians practice in organizations where system-based hazards are recognized, clinical and administrative disciplines face the challenge of defining accountability for team-based performance.

Consider the example of central line-associated bloodstream infections, which cost billions of dollars and cause thousands of deaths annually, even though evidence shows that most of the infections are preventable (Pronovost et al., 2006; Pronovost et al., 2010), and a national program exists to reduce them (Sawyer et al., 2010). The federal government funds hospital participation in this program and ties reducing infections to federal payment policy. The program, which is voluntary, has specific clinical expectations for physicians and nurses. Evidence from hundreds of participating hospitals demonstrates the ability to reduce these infections to nearly zero and sustain the improvements. However, nearly zero is not zero: When these infections occur, how does one assign accountability? If nurses or physicians did not comply with evidence-based procedures, are they accountable? If yes, how? These are difficult questions.

Organizational Accountability

Health-care administrators are facing increased accountability for clinical quality and safety, in part because of public pressure for health care to become highly reliable and in part because the explosion of health-care technologies and costs is drawing intense scrutiny from payers and policymakers (Blumenthal & Glaser, 2007). When considering the individual culpability of nurses for quality and patient-safety outcomes, regulators benefit from a common appreciation of systems theory and a thorough understanding of organizational drivers of quality and patient-safety performance. Drivers are often but not exclusively established by payers—the Centers for Medicare & Medicaid

FIGURE 1

Exploring Accountability for Quality and Patient-Safety Events

The five steps below provide one method for exploring accountability. The accompanying tool helps the user with part of the process.

1. Review the case (root-cause analyses, patient records, legal documents).
2. Place an "X" to signify the likelihood that each of the following is accountable: organization, team, individual, and other.
3. Determine if sanctions are codified for each domain. If sanctions exist, place an "X" to signify their severity.
4. Develop an action plan to explore the gaps between presumed culpabilities and codified sanctions.
5. Consider findings from review in case-specific board actions and consider gaps between presumed accountability and existing sanctions in regulatory-board strategic planning.

Accountability	Certain	Almost Certain	Likely	Possible	Unlikely
Organization					
Team					
Individual					
Other (vendor, device, or drug manufacturer, etc.)					
Sanctions Exist		Severe	Moderate	Minor	None
Organization	Federal or state criminal sanctions				
	Operational sanctions (license or accreditation)				
	Payer policy (economic or participation penalty)				
	Hospital policy				
	Other				
Team	Federal or state criminal sanctions				
	Operational sanctions (license or accreditation)				
	Payer policy (economic or participation penalty)				
	Hospital policy				
	Other				
Individual	Federal or state criminal sanctions				
	Operational sanctions (license or accreditation)				
	Payer policy (economic or participation penalty)				
	Hospital policy				
	Other				

Services and private insurers—as well as accrediting agencies (Joint Commission, 2009).

Payment policy has been the main mechanism of accountability, but that is beginning to change. Boards and administra-

tors are increasingly expected to provide appropriate support for evidence-based clinical practice in their institutions.

If organizations choose not to participate in the federally funded program to prevent catheter-related bloodstream infec-

TABLE 2

Goals to Facilitate the Nursing Transformation

The Institute of Medicine report, *The Future of Nursing: Leading Change, Advancing Health*, positions nurse regulators to provide leadership on the critically important challenge of how to assign accountability for quality and patient safety at the state and local level. The report identifies four goals (as below) to facilitate nursing transformation. Each has irrefutable implications for nursing regulators and links to the need for high quality, safe care.

1. Nurses should practice to the full extent of their education and training.
2. Nurses should achieve higher levels of education and training through an improved educational system that promotes seamless academic progression.
 - Patient needs have become more complicated, and nurses need to attain requisite competencies to deliver high-quality care. These competencies include leadership, health policy, system improvement, research and evidence-based practice, teamwork and collaboration, and competency in specific content areas, including community and public health and geriatrics.
3. Nurses should be full partners with physicians and other health-care professionals in redesigning health care in the United States.
 - Leadership development and mentoring programs need to be made available to nurses at all levels.
 - Nurse leaders must foster a culture that promotes and values leadership.
 - All nurses must take responsibility for their personal and professional growth by developing leadership competencies and exercising them across all care settings.
4. Effective workforce planning and policy making require better data collection and an improved information infrastructure.

tions, should the government or patients hold administrators accountable for such infections? If yes, how? If the organization fails to establish policies and provide support for evidence-based care, are nurses accountable for infections if their actions are not evidence-based? If yes, how? Regulatory bodies must wrestle with the interplay of systems and individuals in the delivery of care.

Economic Accountability

The economic influence on individual and organizational decisions regarding health-care delivery cannot be overstated. Economic pressures, such as basing payment on performance measures to reward high quality providers, can be helpful. However, economic pressures can be harmful, such as when caregivers feel they must save money by cutting corners (McKnight & Bennington Travis, 2008). Nurse administrators and nurses at the point of care should understand that economic pressures

never supersede adherence to licensure requirements or scope of practice.

Political Accountability

Political and policy-level accountability for quality and safety is front and center in the new health reform legislation and in the swirl of confusion that exists about patient choice, caregiver choice, and payer choice. National recommendations have significant implications for local practice and call for nurse regulators to be leaders at the table with physicians, insurers, and policymakers.

Aspects of Accountability

Specifics vary among clinical, organizational, economic, and political models of accountability, but the questions that guide the models are the same: Who is accountable? For which issues are they accountable? What are the appropriate methods for holding them accountable?

All quality issues are not the same, and different types of accountability apply to various aspects of health-care delivery. Thus, regulators may benefit from use of a framework in their basic assessment of accountability in quality-of-care issues brought before the board. Yet even if basic tools help clarify areas for further investigation, and if nursing regulators address the suggestions in the accountability models, their work will have only begun.

On October 7, 2010, the IOM released *The Future of Nursing: Leading Change, Advancing Health* that builds on the Affordable Care Act. This IOM report calls for a vision of health care that will require the transformation of many aspects of the health-care system, “especially the nursing profession, whose more than 3 million members represent the largest segment of the healthcare work force.” This report has the potential to stimulate standardization of nurse practice: “The federal government is particularly well suited to promote reform of states’ scope-of-practices laws by sharing and providing incentives for the adoption of best practices” (Shalala et al., 2011).

Nurse regulators have expertise in both the evolution of nursing practice and the current legitimate roles and responsibilities of registered nurses across the country. Thus, they must become a significant part of the beacon of leadership called for in this latest IOM report. (See Table 2.)

Summary

We are learning that accountability improves when providers are involved in creating safer systems. The 10 years after *To Err is Human* focused on understanding that system issues contribute to errors. Today’s challenges are to discern the dimensions of individual and team accountability within the context of systems accountability, to develop cross-discipline principles that

minimize the risk of disproportionate responses after an error, and to disseminate this knowledge widely.

The 1999 IOM report unleashed public awareness of the need to improve health-care quality and patient safety. The 2010 IOM report may be the tsunami that unleashes the potential of the nursing profession and expedites measurable health-care improvement. Courageously addressing challenges of accountability versus blame through collaboration with medical and administrative colleagues will position nursing regulators to lead the next transformation.

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Learning Objectives

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CE Posttest

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Posttest

Please circle the correct answer.

1. Which statement about systems theory is correct?

- It focuses on individuals.
- It is unrelated to systems thinking.
- It provides a set of concepts that are specific.
- It focuses on relationships and interactions.

2. To assess accountability and quality and patient safety in a specific case, it is helpful to use a matrix that includes accountability and:

- patient preferences.
- sanctions.
- licensure data.
- incentives.

3. Which is NOT an example of a sanction?

- Hospital policy
- Payer policy
- Federal law
- Vendor suggestions

4. "Nurses should practice to the full extent of their education and training" is one of the goals in which of the following?

- The Future of Nursing: Leading Change, Advancing Health*
- To Err is Human*
- Centers for Medicare & Medicaid Services Special Report
- Social Transformation of American Nursing

5. Which statement about the evolution of medical practice is correct?

- Core educational curricula, licensure regulations, and uniform standards of practice emerged in the 1990s.
- Core educational curricula, licensure regulations, and uniform standards of practice emerged in the 1910s.
- By the 1980s, the growth of diagnostic and treatment options made care and accountability more complex.
- By the 1970s, the growth of diagnostic and treatment options made care and accountability more complex.

6. Which statement about the evolution of nursing practice is correct?

- Nurse practice acts vary from state to state.
- Nurse practice acts are consistent from state to state.
- Nursing curricula are standardized.
- Licensure exams test advanced knowledge.

7. Which statement about clinical accountability is correct?

- Accountability should be based solely on licensure.
- Scope of nursing and medical practice can overlap.
- Accountability is easy to assign when an error occurs.
- Regulators should not strive to develop standardized principles for assessing behavior.

8. Which statement about economic accountability is correct?

- Economic accountability should not supersede licensure requirements.
- Economic accountability should be an integral part of scope of practice.
- Economic accountability means payment should not be linked to performance.
- Economic accountability means that all hospitals should receive the same reimbursement.

9. A landmark 1999 Institute of Medicine report stated that errors of commission cause how many needless deaths a year in hospitals?

- Nearly 100,000
- Nearly 200,000
- Nearly 300,000
- Nearly 400,000

10. An example of an influence that is making care delivery more difficult and regulation increasingly ambiguous is:

- a population that is getting younger.
- a lack of development in biotherapies.
- an explosion of information technology.
- insufficient patient-safety performance measures.

11. Which development was a critical step to creating uniform nursing standards?

- State board tests
- NCLEX
- Individual state boards
- State licensure

12. Which educational factor makes it difficult to balance accountability and blame?

- a. The lack of development in diagnostic technologies
- b. Basic preparation with clearly defined follow-up education
- c. Baccalaureate programs with a large clinical component
- d. A lack of uniform requirement for continuing nursing education

13. Regulatory boards that want to establish nurse accountability for quality and patient safety need to be sure the following exist:

- a. Well-defined quality metrics
- b. Broad quality standards
- c. Expectations that vary per individual
- d. Penalties for violations that vary per hospital

14. Which statement about systems thinking is correct?

- a. Systems thinking states that individual competency is the only factor to be examined in an error.
- b. Systems thinking requires that the nurse responsible for an error should shoulder the blame.
- c. Systems thinking views problems from the perspective of interrelationships, factors, and microsystems in an overall system.
- d. Systems thinking views problems from the perspective of silos of information that do not interact.

15. Which statement about nurse leadership is correct?

- a. All nurses must develop leadership competencies.
- b. Only nurses seeking management roles need to develop leadership competencies.
- c. An organization should not offer leadership mentoring programs to staff.
- d. Only baccalaureate nurses need to develop leadership competencies.

Evaluation Form (required)

1. Rate your achievement of each objective from 5 (high/excellent) to 1 (low/poor).

- Describe how accountability relates to patient safety and quality.

1 2 3 4 5

- Identify at least two types of accountability.

1 2 3 4 5

- Define systems theory and systems thinking.

1 2 3 4 5

Rate each of the following items from 5 (very effective) to 1 (ineffective):

2. Were the authors knowledgeable about the subject?

1 2 3 4 5

3. Were the methods of presentation (text, tables, figures, etc.) effective?

1 2 3 4 5

4. Was the content relevant to the objectives?

1 2 3 4 5

5. Was the article useful to you in your work?

1 2 3 4 5

6. Was there enough time allotted for this activity?

1 2 3 4 5

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