Quality and Nursing: Moving from A Concept to a Core Competency

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Most health care providers begin their health profession education expecting to acquire the knowledge and skills needed to provide high-quality care. However, as they advance through their education and begin their careers, they discover that health care systems are exceedingly complex, with a myriad of system issues that often make the provision of high-quality care difficult.

Over the past several years, many reports have outlined the problems in quality that plague the health care delivery system. Chassin and Galvin (1998) identified pervasive underuse, overuse, and misuse of health care resources as a quality problem. Investigations of adverse drug events (Bates et al., 1995; Leape et al., 1995) revealed surprising frequencies of medication-related harm, and studies exploring the risk of injury from medical errors challenged long-held beliefs that health care systems worked only for the good of patients (Brennan et al., 1991; Leape et al., 1991). The Institute of Medicine (2001) defined aims for improving the functions of the health care system, stating that care should be safe, effective, patient-centered, timely, efficient, and equitable. However, even a cursory examination of much of the care received by the majority of patients reveals that these aims are often not realized. Health care providers begin their health profession education expecting to acquire the knowledge and skills needed to provide high-quality care. However, as they advance through their education and begin their careers, they discover that health care systems are exceedingly complex, with a myriad of system issues that often make the provision of high-quality care difficult.

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errors continue to occur at alarming rates, with approximately 3% to 4% of hospitalized patients suffering a serious adverse event (Thomas et al., 2000) and as many as 1 in 200 hospitalized patients dying of a preventable adverse event (Baker et al., 2004).

The time required for best evidence to be integrated into clinical care may be improving, but remains far longer than the ideal (Lee, 2007). Accounts of personal experiences written by recent recipients of health care are replete with reminders that health care systems are often not truly patient-centered (Cleary, 2003). Delays in achieving needed care cause frustration and at times compromise outcomes (Murray, 2002). Per capita health care expenditures in the U.S. remain higher than those of any other industrialized nation; yet, over 45 million individuals in the U.S. lack even basic health insurance (Porter & Teisberg, 2006). These data attest to the reality that the current care system does not consistently deliver care that is safe, effective, patient-centered, timely, efficient, or equitable. The Institute of Medicine (2001, p.1) defined this failure in care delivery as “not a gap, but a chasm.” This article will define quality as a core competency for health professionals and provide a description of how nurses are contributing to quality improvement.

What Is Quality?

A brief review of what is meant by “quality” may help set the stage for a discussion of the role of nurses in quality care. The most commonly quoted definition for health care quality is provided by the Institute of Medicine (2001, p. 44), describing 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.” The Joint Commission (previously known as The Joint Commission on Accreditation of Healthcare Organizations or JCAHO) has been a highly visible force attempting to focus health care institutions on quality of care for over 50 years (Thrall, 2004). However, only in the past few years did the focus of The Joint Commission expand from review of policies, facilities, and credentials to include exploration of process improvement, patient safety, and outcomes. In the 1980s and 1990s, much of the quality literature focused on the impact of reimbursement systems, such as DRGs, or managed care structure on the achievement or inhibition of desired patient outcomes (see Figure 1) (Dolenc & Dougherty, 1985; Hellinger, 1998; Krumhotz, 1999).

Quality assurance, the measurement of characteristics of a product to ensure conformity to standards, became widespread in health care during the 1980s. The emphasis on quality measurement fostered discussion about validity of quality measurements and outcomes assessment (Bolmey, 2002; Bostick, Riggs, & Rantz, 2003; Saltzer, Nixon, Schut, Karver, & Bickman, 1997). Evidence-based care and the importance of health care informatics emerged as important themes during the 1990s, fostering development of clinical care paths and practice guidelines (Campbell, Hotchkiss, Bradshaw, & Porteous, 1998). From the late 1990s to the present, quality improvement, using systematic processes to improve health care delivery, has assumed national prominence within health care organizations (Berwick, 1996).

Patient safety has become a major focus area for virtually all health care systems within the past 10 years. The integration of performance improvement models and techniques from industry into health care has been accelerated by the expanding utilization of Baldrige criteria for evaluation of the efficiency and effectiveness of health system operations (Foster, Johnson, Nelson, & Batalden, 2007). Batalden and Davidoff (2007) noted that health care workers need to acquire more than just the professional knowledge related to their discipline to improve care. Knowledge of local culture at the site of care delivery, knowledge of quality...
improvement tools, measurement knowledge, and an understanding of how to manage change are all essential knowledge bases for a health professional seeking to positively change a system of care. The Institute of Medicine (2003) recognized the need for health professionals to acquire specific skill sets relating to the quality of care during their educational programs.

With an expansion of these skill domains to include the area of patient safety, the leaders of Quality and Safety Education for Nurses (QSEN) outlined six skill domains, with associated requisite knowledge, skills, and attitudes identified as competencies for each of the domains (Cronenwett et al., 2007). Although the language used to describe some of these competencies may be new, nursing leaders have recognized that many of the concepts embodied within these domains represent a return to core values, such as patient advocacy and health professionals working together, foundational elements upon which the nursing profession is built (Salmon, 2007). Whether recent graduates or seasoned veterans, many nurses will find that discussions of the need for safe, patient-centered, high-quality care resonate with the values that drew them into nursing. However, most would also acknowledge that the knowledge and skills required to improve the quality of care delivered were not always emphasized during their training. By learning more about quality competencies through continuing nursing education and participation in improvement activities, nurses can enhance their effectiveness as members of health care teams and can accelerate the pace of change within their workplace.

**Nursing Involvement in Quality – What Are the Benefits?**

Even as health care leaders seek ways to meaningfully address the quality gap, many health care providers are left wondering what role they can play in solving health care system woes. Other than trying to ensure that the care they give to individual patients is attentive, many providers feel that the systems are too large and complex for them to have a meaningful impact. Despite the intensifying rhetoric about quality among payers, regulators, and patients, many health care workers, including nurses, feel they are consigned to spend their careers working within a dysfunctional system, leading to professional dissatisfaction or even burnout.

Properly understood, the competencies associated with quality can greatly impact the day-to-day lives of nurses. Many central issues influencing job satisfaction for nurses, including patient flow problems, safe management of high census periods, communication problems around complex patients, and improving medication safety, can be potentially addressed by systematic quality improvement initiatives. Nursing leaders can partner with other health care system leaders to create a culture that views challenges in care delivery as opportunities for team-based interprofessional systematic improvements. Not only will a greater understanding of these competencies prepare nurses to deliver the kind of care they desire for their patients, but the knowledge, skills, and attitudes embodied within these competencies can help increase their joy in work and prepare them for the rapidly changing landscape of regulatory quality. Involvement of nurses in improvement efforts may lead to a more positive perception of their work environment (Hall, Doran, & Pink, 2008), and may also lead to higher levels of patient satisfaction (Lindberg & Kimberlain, 2008; Thrall, 2008). In the appropriate setting, participation of nurses in quality improvement has specifically led to increased perception of institutional interest in the well being of the employees and perceptions of increased involvement in work decisions (Varkey, Karlapudi, & Hensrud, 2008). Although nurses today face many challenges, by learning and utilizing specific competencies related to quality, they may increase the effectiveness of their advocacy for patients, increase the value they bring to the institutions in which they work, and enhance the satisfaction they derive from nursing throughout their careers.

**Serving as a Patient Advocate**

Advocacy on behalf of patients has long been expressed in many core nursing functions, including the integration of care, provision of emotional support, education of patients and families, assistance with compensation for loss of function, and monitoring of patient status (Institute of Medicine, 2004). However, nurses may also play a vital role as champions for safer, more efficient systems of care. Through participation in interprofessional improvement teams, nurses may help create new care protocols and care pathways that will serve as the standard of care for numerous patients. By utilizing safety reporting systems to alert institutional leaders to patient safety risks, nurses may stimulate improvements that will raise the quality of care for all patients in their facility.

Following adverse events in health care, many nurses provide valuable insights into care processes when working with patient safety leaders as part of a root cause analysis team. Nurses’ unique knowledge of the care provided is essential for designing the best improvements in care processes. Contributing their expert understanding of “real world” nursing to such improvements is professionally gratifying work that most nurses feel will lead to more robust patient safety innovations (Hall et al., 2007).
Nursing Narrative: Patient Advocacy

With 10 years of intensive care unit (ICU) nursing experience, Michelle knew the importance of good teamwork and communication. When a patient who had just completed a complex surgery was wheeled into the ICU without advance notice, she realized that the lack of communication from the OR team prior to the transfer hampered her ability to give optimal care. Once the patient was stabilized, she entered her concerns into the institution’s safety reporting system. Although this patient ultimately had a good outcome, she suggested that the development of a standardized transfer protocol for passing along information from the OR to the ICU would improve both communication and efficiency of care. When the hospital’s safety officer asked Michelle to serve on the root cause analysis team looking at this incident, she agreed. Working with physicians and other nurses from the OR and ICU, the team developed a new standardized communication tool for all urgent OR to ICU transfers. Two years later, this improved “handoff” tool is still in use and has benefitted the care of dozens of patients.

Nursing Narrative: Joy in Work

An experienced hospital nurse and nurse practitioner, Jolene had always worked hard to provide her patients with quality care. When several patients complained that their pain was poorly controlled while hospitalized on her unit, she wondered why the care system was failing them. Although she had no formal training in quality improvement, she knew that solving this problem would require cooperation of many different health professionals who contributed to the care of her patients. She convened a meeting of physicians, pharmacists, and nurses who worked on her unit, and they agreed together to begin an improvement project to address the problems with pain control among their patients. One year and at least a dozen improvement team meetings later, the unit members had implemented standardized pain protocols that provided much more timely and effective analgesia for their patients who were experiencing pain. Press Ganey patient satisfaction with pain management scores on the unit increased dramatically during the previous year. Jolene reflected that participating in this improvement team had been the most rewarding experience of her 25-year nursing career.

Figure 2 provides one nurse’s account of how advocacy to improve quality added value to her work and the care processes in her unit.

The Link Between Quality Care And Achieving Joy in Work

A major reason for achieving any aim, including the delivery of quality health care, is experiencing joy in work. Clinicians get up every day wanting to do a good job – to provide not average care, but the best care. When nurses believe that they are not just giving care but improving care, the joy they derive from their work increases. When given the opportunity to use their ability to problem solve, take responsibility for their actions, and create new systems, nurses experience joy at work (Neave, 1990). Improvement of care systems by nurses satisfies their natural desire to feel useful and creative, and to work as part of a team contributing to a larger purpose. Developing an inquisitive mind that constantly seeks to better understand systems of care is as essential as celebrating work successes and enjoyment. Continuously looking for opportunities to improve patient care is one way for health care professionals to come alive, to have fun, and to improve the joy they experience in their work. In turn, innovations introduced by health care professionals who work to improve care systems provide enduring benefits for many patients.

One way of building environments for improvement and greater joy in work is to move to affirmation models to guide nurses’ thinking and actions. Appreciative inquiry is an affirmation process of organizational change that focuses on the positive and creative as forces for a more positive future. Appreciative inquiry is the study and exploration of what gives life to human systems when they function at their best. Developed by David Cooperrider in the mid-1980s (Whitney & Trosten-Bloom, 2003), appreciative inquiry is a method of organizational development in which the “best of what is” is made better (Cooperrider, Whitney, & Stavros, 2005). In this process, positive change is facilitated through energized and creative images of possibility based on strengths. Appreciative inquiry achieves its positive outcomes utilizing a simple principle: things that are affirming engender a force toward them. Thus, behavior (continuous improvement processes) is aligned with the positive images that are visualized and supported through building on best practices. As health care professionals are confronted by staff shortages, shrinking resources, and sicker patients, nurses are challenged with the far-sighted objective of transforming care to be the best care. Joy in work plays a large part in that context. Figure 3 provides another narrative of a nurse who found involvement in a quality improvement project regarding pain control to be the most invigorating experience of her nursing career.

The Contributions of Nurses to Regulatory Quality

For hospital-based nurses, many activities that comprise their daily routines are linked either directly or indirectly to meeting regulatory quality standards. These standards may
include those originating from Federal Medicare and Medicaid programs, and State Department of Health and other accrediting bodies (such as The Joint Commission), all of which focus on quality enhancement processes. Increasingly, third party payers are adding quality indicators to reimbursement contracts. Pay for performance programs, in which health systems receive additional payment incentives if specific quality targets are achieved, may involve nursing through engagement in quality improvement teams, data collection, or cooperation in the implementation of protocols (Bodrock & Mion, 2008).

Nurses as Agents to Improve Health Care Value

Value-driven health care is emerging as the latest catch phrase to summarize recent trends in the complex relationships between patients, the health care enterprise, and purchasers of health care (Kennett, 2006). The concept of value in health care relates to the return realized on investment made in care. Numerous studies suggest that Americans, who enjoy the most expensive health care in the world, do not feel that they are getting their money’s worth (Porter & Teisberg, 2006). For many years, quality improvement has been touted as a strategic investment that not only improves care but enhances financial stability of health care systems (Reiter, Kilpatrick, Greene, Lohr, & Leatherman, 2007). However, the current focus on value-driven health care has engaged health care system leaders in strategic discussions of “the business case for quality” with an intensity and immediacy not previously realized. Many purchasers are following Centers for Medicare and Medicaid Services’ (CMS) lead in withholding payment for preventable complications of care (Pronovost, Goeschel, & Wachter, 2008). As pay-for-performance, uniform measurement and reporting of quality measures, and transparency of quality metrics become a reality, no health system leader can fail to recognize the large implications of quality care in their system’s overall success.

So what role should nurses play in the new world of value-driven care? Although cost effectiveness may not always be the primary motivation for improving quality, many changes can simultaneously decrease costs while enhancing outcomes (Bodenheimer & Fernandez, 2005). When working to improve patient safety, decreasing adverse events can often lead to a decrease in the cost of care (Hwang & Herndon, 2007). Improvement initiatives to safeguard skin integrity, prevent nosocomial infection, and prevent venous thromboembolism are broadly utilized to decrease complications in hospitalized patients, with nurses playing key roles in most such initiatives. Health care systems increasingly stress efficient practice to avoid waste, introducing “lean” methodologies adopted from other industries. Nurses working within systems trying to “go lean” will find that they are challenged to eliminate unnecessary steps and reduce wasted resources as they improve processes. While this may demand new skills and disciplines that are initially unfamiliar to many nurses, the improvements in work flow accomplished by such processes can improve job satisfaction and patient care (de Koning, Verver, van den Heuvel, Bisgaard, & Does, 2006; Shumaker, 2007).

The increasing migration of nursing documentation to the electronic health record (EHR) is also being driven by the search for value in health care (Dwivedi, Bali, Wickramasinghe, & Naguib, 2007). Although the growing use of EHRs has improved nurses’ access to important information and provided useful safety alerts, many nurses find that using EHRs poses a high demand on work time, with resulting negative impacts on quality of care (Kossman & Scheidenhelm, 2008). The current generation of nurses must help health care system leaders design systems of care that use information resources to improve quality and safety while preserving time for bedside nursing functions.

Getting Started in Quality Improvement

Involvement in the work of improving quality is not a task that can be relegated to a few hospital employees who specialize in this area. In today’s health care system, providers are expected to
contribute to the improvement of care. However, because many current health professionals completed their education prior to the introduction of these concepts into health professions curricula, resources are needed to backfill the knowledge and skills required to excel in this work.

Developing Personal Competencies to Contribute Meaningfully

Based on work by the Institute of Medicine (2003), leaders of the QSEN (Cronenwett et al., 2007) defined six competencies to guide professional development: Patient-Centered Care, Teamwork and Collaboration, Evidence-Based Practice, Quality Improvement, and Safety and Informatics. Each competency has requisite Knowledge, Skills, and Attitudes. Simply stated, there are specific domains of knowledge that must be mastered, skills that must be developed, and attitudes that must be cultivated if a nurse is to deliver high-quality, safe, patient-centered care as a member of a health care team. The Quality Improvement competency is defined as using “data to monitor the outcomes of care processes and use improvement methods to design and test changes to continuously improve the quality and safety of health care systems” (Cronenwett et al., 2007, p. 127). Knowledge a clinician needs to meet this competency includes understanding variation and measurement to assess quality of care, knowing strategies for learning about the outcomes of care related to one’s practice (for example, knowing the wound infection rate in one’s area of specialty), and designing approaches to decrease rates. This requires the clinician to have access to data about clinical outcomes, the ability to use data to benchmark with local and national databases to identify gaps in best practice, and how to use an improvement model to design, implement, and test changes in daily work.

Understanding Tools Used to Improve Care

Professor George E. Box said, “All models are wrong, but some of them are useful” (Draper, 1987, p. 424). Many health care settings have a quality improvement model that drives all quality improvement activities. The selected model should be used consistently in every department or function in the quality improvement teams that are working. A well-known quality process is the plan/do/check/act (PDCA) cycle. Six Sigma is another commonly used improvement model in health care (Antony, 2008). Several of the more frequently used models or paradigms are summarized in Table 1.

Numerous tools exist to assist clinicians in the quality improvement process. Several basic tools that facilitate the quality improvement process and allow improvement work to proceed more rapidly and systematically include flowcharts, check sheets, Pareto diagrams, cause and effect diagrams, histograms, scatter diagrams, and control charts (Hughes, 2008; Langley, Nolan, Nolan, Norman, & Provost, 1996). Table 2 summarizes some of the tools that are utilized most frequently in quality improvement work. Although many nurses may lack formal training in the use of some quality improvement tools, developing a working familiarity with these tools heightens the likelihood that changes implemented during improvement work will be targeted at high-yield areas and will produce enduring results.

Importance of the Interprofessional Approach to Improving Quality and Safety

Continuous quality improvement is based on the concept that improvement comes from build-

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**Table 1. Models Used to Improve Quality of Care**

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<thead>
<tr>
<th>Name</th>
<th>Explanation</th>
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<tbody>
<tr>
<td><strong>Prospective Models (used to design systems or prevent problems)</strong></td>
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<tr>
<td>PDCA</td>
<td>Plan-Do-Check-Act: Four-step improvement process that begins with planning the intervention, implementing the change, measuring results, and using the result to plan further improvements in the system.</td>
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<tr>
<td>DMAIC</td>
<td>Define-Measure-Analyze-Improve-Control: A five-phase methodology for improving an existing process, usually used as part of a Six Sigma approach to improvement.</td>
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<tr>
<td>DMADV</td>
<td>Define-Measure-Analyze-Design-Verify: A five-phase methodology for designing a new process, usually used as part of a Six Sigma approach to product or service design.</td>
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<tr>
<td>Six Sigma</td>
<td>An improvement strategy that seeks to identify and remove causes of defects within a process. This approach focuses on team preparation and charter, defining customer expectations, process mapping, and careful ongoing measurement of results.</td>
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<tr>
<td>HFMEA</td>
<td>Healthcare Failure Mode Effects Analysis – Another engineering term that has been adopted by health care. This process analyzes a new process or product to determine potential points of weakness or failure prior to implementation.</td>
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<tr>
<td><strong>Retrospective Model (used to analyze past occurrence)</strong></td>
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<tr>
<td>Root Cause Analysis (RCA)</td>
<td>Examines an unexpected outcome or adverse event to identify the underlying system vulnerabilities that led to its occurrence. This process is often used to investigate sentinel events or other adverse health care events. The cause and effect diagram (see Table 2) is a quality improvement tool often utilized as part of a root cause analysis.</td>
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Table 2.
Quality Improvement Tools

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<tr>
<th>Quality Improvement Tool</th>
<th>Primary Use</th>
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<tr>
<td>Flowchart</td>
<td>Flowcharts describe a process in as much detail as possible by displaying all the steps in proper sequence. Quality improvement teams use flowcharts to identify areas of vulnerability, indicate areas for further improvement, and help explain and solve a problem. By flowcharting all the steps in the care of a patient with a Foley catheter, the quality improvement team may identify where common breaches of technique might occur.</td>
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<tr>
<td>Check Sheet</td>
<td>Check sheets help organize data by category. They show how many times each particular value occurs, and their information is increasingly helpful as more data are collected. Check sheets help clinicians spot problems. Using a check sheet for surveillance of a health care provider’s adherence or lack of adherence to proper hand hygiene techniques helps pinpoint where action is needed.</td>
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<tr>
<td>Pareto Diagram</td>
<td>The Pareto diagram puts data in a hierarchical order, allowing the most significant problems to be corrected first. Data are grouped in categories in order of frequency, and a bar graph is created based on the results.</td>
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<tr>
<td>Cause and Effect Diagram</td>
<td>The cause and effect diagram is also known as a fishbone diagram because of its shape. It displays all contributing factors and their relationships to the outcome to identify areas where data should be collected and analyzed.</td>
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<tr>
<td>Histogram</td>
<td>The histogram plots data in a frequency distribution table. A histogram works best with small amounts of data that vary considerably.</td>
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<tr>
<td>Scatter Diagram</td>
<td>A scatter diagram shows how two variables are related, and is used to test for cause and effect relationships and demonstrate if a relationship exists and how strong it is.</td>
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<tr>
<td>Control Charts</td>
<td>Control charts display statistically determined upper and lower confidence limits drawn on either side of a mean.</td>
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Continuous quality improvement is the process of providing care that is more economical and/or care that yields improved outcomes, using systematic methods and interprofessional teamwork. There is considerable evidence that interprofessional teamwork and enhanced communication reduce errors (Mann, Marcus, & Sachs, 2006; Morey et al., 2002), improve patient outcomes (Lau, Banaszak-Holl, & Nigam, 2007; Pronovost, Berenholtz, & Dorman, 2003), improve process outcomes (Pisano, Bohmer, & Edmondson, 2001), improve patient satisfaction (Lefebvre, Pelchat, & Levert, 2007), and increase staff satisfaction (DiMeglio, Lucas, & Padula, 2005). The Institute of Medicine (2003) described the ability to function effectively in interdisciplinary teams as one of five basic competencies needed by health professionals to bridge the quality gap in the U.S. health care system. In health care, however, interprofessional teams frequently have little or no training in team process, and teams are not routinely trained to collaboratively give and improve care (Barnsteiner, Disch, Hall, Mayer, & Moore, 2007).

Interprofessional teams are composed of individuals from diverse professional disciplines, each having its unique tradition, culture, and language that describe its healing relationship to the patient or client differently. Achieving improved health outcomes usually lies outside the scope or control of any one member of the health care team (Headrick, Wilcock, & Batalden, 1998). However, because each member of the team contributes to the patient’s care from his or her area of expertise, a therapeutic synergy is possible when working in collaboration with other health professionals. Traditionally, students are enculturated into their discipline’s worldview and trained to assume specific roles and perform autonomously (Drinka, 1996; Toner, Miller, & Gurland, 1994). For interprofessional teams to function effectively, each member must understand not only the roles and language of other team members, but how to function collaboratively to integrate their expertise for quality care (Wadsworth & Fallcreek, 1997).

The importance of interprofessional teamwork and communication has recently been addressed by the Agency for Healthcare Research and Quality (AHRQ) and the Department of Defense in their development of a recommended standard training program (Team STEPPS) for interprofessional health care teams (King et al., 2006). TeamSTEPPS stands for Team Strategies and Tools to Enhance Performance and Patient Safety. The TeamSTEPPS program’s educational materials, which focus on specific skills supporting team performance principles, including training requirements, behavioral methods, human factors, and cultural change designed to improve quality and patient safety, are provided free from AHRQ (King et al., 2006).

When health care professionals understand each other’s roles and are able to communicate and work together effectively, patients are more likely to receive safe, quality care. Team members learn through the process of con-
tional movement between practice and reflection on practice. This promotes higher performance in the short-term, while building a learning culture for the long-term. Well-functioning interprofessional teams not only recognize and build on the contributions of others, but they also focus on improving their process and their product through conscious and continuous cycles of learning together.

**Summary: Taking the Next Step**

Nurses are uniquely positioned to serve as change agents within health systems. By partnering with other health care providers who share their vision for improving care and by linking with institutional quality professionals, the impact of nursing improvement efforts is heightened. With an unprecedented number of print and Web-based resources available to assist with this work, developing competence in this area is within the reach of all nurses. As health care systems increasingly recognize the value of this work, nurses find that their contributions to care improvement lead not only to a sense of personal reward, but may lead to professional advancement. Investment in the development of skills in quality improvement provides a means for nurses to improve the lives of patients, build their own careers, and improve the joy they derive from their work.

**References**


