The call for nurse leadership at the bedside has been emerging over the last 15 years. Since the publication of the Institute of Medicine’s (IOM) report, *To Err is Human, Building a Safer Health System* (IOM, 1999), the demand has increased for clinical nurses to take the lead in ensuring quality patient care, patient safety, and healthy practice environments. While clinical nurses are expected to assume leadership roles to enhance patient outcomes, guarantee patient safety, and assure efficient work processes, many of them lack the knowledge and skill. To assume leadership roles at the point of service, nurses must master the essential knowledge and skills of clinical leaders.

Four landmark IOM reports provide the framework for the development of clinical leaders by identifying the need for (a) environmental changes in health care to decrease medical errors (IOM, 1999), (b) redesign of clinical services to assure quality care (IOM, 2001), (c) elimination of variations in practice (IOM, 2004), and (d) development of clinical leaders to spearhead change initiatives in the practice environment (IOM, 2011). A significant nursing directive has evolved from these four IOM reports: Clinical nursing leadership at the point of service now is recognized as a central professional competency to ensure quality patient care and patient safety.

Nurse leaders at the bedside are clinical experts who provide direct patient care that continually improves patient outcomes and enhances the practice environment. They are empowered clinical experts who demonstrate emotional intelligence, challenge ineffective work processes, and inspire others to act. These nurse leaders recognize their power, professional and ethical responsibilities, and clinical autonomy to engage in decision-making related to patient care and nursing practice in an interprofessional practice environment (Benner, 2001; Benner, Sutphen, Leonard-Kahn, & Day, 2008; Cook, 2001; Downey, Parslow, & Smart, 2011; Kouzes & Posner, 2007; Stanley, 2006; Weston, 2008).

The benefits of being a clinical leader at the bedside are many. Clinical leaders report greater job satisfaction, increased personal satisfaction in their own accomplishments, and more opportunities for career advancement. In addition, they take great pride in the accomplishments of those they have influenced. Clinical leadership at the point of service also has benefits for the employing agency. The delivery of patient care services is enhanced as patient safety, care, outcomes, and satisfaction are improved; work processes are more efficient; errors are reduced; and waste in the workplace is eliminated. These enhancements support a healthy practice environment (Downey et al., 2011; George et al., 2002).

Regardless of the benefits of being a clinical leader, many nurses do not seek leadership roles in their practice environments. Many reasons are given for the declining interest in a leadership role. Nurses indicate they are too busy with patient care, lack the necessary knowledge and skills for leadership, do not want to take on more work, or do not believe they have the power to lead in their workplace.

Clinical nurses are expected to assume leadership roles to enhance patient care and assure efficient work processes. Dimensions of clinical leadership and the essential knowledge and skills of the clinical leader are described.
Also some nurses do not recognize or acknowledge their professional responsibility to assume a leadership role in their practice environment. In reality, nurses have the freedom and authority to make nursing care decisions concerning patient care and work processes (Weston, 2008).

**Determination of Essential Knowledge and Skills**

In recognition of the need for clinical leadership at the point of service, the Academy of Medical-Surgical Nurses (AMSN) assembled a task force of clinical and leadership experts to develop a curriculum for leadership development for medical-surgical nurses at the point of service. This task force reviewed the literature and the IOM reports, obtained input from nurse experts and leaders, and evaluated research findings from AMSN’s Nurses Nurturing Nurses program. Following a series of discussions, the content was rank-ordered to determine essential knowledge base and skills for clinical leaders. The curriculum information was compiled into eight categories, each containing two topics. Ten of the topics were designated as basic knowledge for clinical leaders at the bedside. Two topics focused on the role, characteristics, and skills of the clinical leader and the part motivation plays in clinical leadership; these areas are not presented in this article. The remaining six topics were categorized as advanced knowledge and skills for the clinical leader at the bedside and will be addressed in the future.

The core knowledge topics are discussed in the next section. The competency skills of clinical leaders at the bedside follow.

**Core Knowledge for Clinical Leadership**

The eight core topics of knowledge have been classified into clinical practice and the practice environment categories (see Table 1). A brief overview of every topic is presented; however, the author encourages readers to engage in an in-depth inquiry into each topic. After a topic is reviewed, use the Clinical Leadership Knowledge Assessment Form (see Figure 1) to rate knowledge of the topic. Reflect on what you know and what you think you would need to do to strengthen your knowledge about each topic.

**Foundations of Quality Care**

Clinical leaders have a strong foundation in health care quality so they can take an informed, active part in quality management initiatives. Quality patient care is grounded in six aims: (a) keep patients safe from injuries; (b) pro-

<table>
<thead>
<tr>
<th>Clinical Practice</th>
<th>Practice Environment</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Foundations of Quality Care</td>
<td>• Hospital Systems</td>
</tr>
<tr>
<td>• National Patient Safety Goals</td>
<td>• Cost Drivers for Nursing Services</td>
</tr>
<tr>
<td>• Core Measures &amp; Hospital Consumer Assessment of Healthcare Providers and Systems</td>
<td>• Healthy Practice Environments</td>
</tr>
<tr>
<td>• Critical Appraisal of Clinical Evidence</td>
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</tbody>
</table>

**TABLE 1. Core Knowledge for Clinical Leadership**

**FIGURE 1. Clinical Leadership Knowledge Assessment Form**

<table>
<thead>
<tr>
<th>How Knowledgeable Are You about the Following?</th>
<th>Not at All Knowledgeable</th>
<th>Somewhat Knowledgeable</th>
<th>Knowledgeable</th>
<th>Very Knowledgeable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Practice</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Quality Initiatives</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>National Patient Safety Goals</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Core Measurements and HCAHPS*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reduction in Practice Variations</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Critical Evaluation of the Literature</td>
<td></td>
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<tr>
<td>Practice Environment</td>
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<tr>
<td>Hospital Systems</td>
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<tr>
<td>Cost Drivers for Nursing Services</td>
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<tr>
<td>Health Practice Environments</td>
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</tbody>
</table>

* HCAHPS: Hospital Consumer Assessment of Healthcare Providers and Systems
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vide effective patient-centered care based on scientific knowledge; (c) provide care that is responsive to patient preferences, needs, and values; (d) deliver timely care; (e) ensure the efficient, cost-effective delivery of services by avoiding waste of equipment, supplies, ideas, and time; and (f) assure quality care is provided regardless of sex, ethnicity, geographic location, and socioeconomic status (IOM, 2001).

The knowledge content for quality care begins with an awareness of the many dimensions of quality as viewed by the patient, nurses, health care professionals, health care organization leaders, insurers, and national quality organization leaders. An awareness of the responsibilities and collaborative efforts of quality organizations such as government agencies (e.g., Centers for Medicare & Medicaid Services [CMS]; Agency for Healthcare Research and Quality [AHRQ]), independent nonprofit organizations (e.g., The Joint Commission; Institute for Safe Medication Practices), and professional organizations (e.g., American Nurses Association [ANA]; American Medical Association) is essential as these organizations assess dimensions of the quality of care, provide funding for health care, and offer resources to assure quality of care. To participate effectively in quality initiatives, clinical leaders must be familiar with Donabedian’s structure, process, outcome (SPO) model (Donabedian, 2005) and other quality improvement models (e.g., Plan, Do, Study, Act [PDSA]; Focus, Analyze, Develop, Execute [FADE]) and tools (e.g., process maps, fishbone diagrams, surveys) (AHRQ, 2013; Wiseman & Kaprielian, 2014). [Rate your knowledge about the foundations of quality care.]

National Patient Safety Goals (NPSGs)

Although evidence suggests the effectiveness of many patient safety practices has improved substantially over the past decade (Shekelle et al., 2013), numerous threats to patient safety remain in all facets of care delivery. Common obstacles to a safe system include (a) complex and risk-prone systems; (b) a lack of comprehensive verbal, written, and electronic communication systems; (c) tolerance of stylistic practices wherein providers do it their way; (d) a lack of standardization of practices; (e) fear of punishment that inhibits reporting; and (f) a lack of ownership for patient safety (IOM, 1999). Without an awareness of the sources of these barriers, nurse leaders at the bedside are less likely to identify safety issues.

Essential knowledge about the NPSGs begins with a brief history of the development of the NPSGs and Sentinel Event Alerts (The Joint Commission, 2014). With insight about the configuration of each NPSG, nurses can identify specific directives for patient care. By recognizing updated NPSGs are published annually and knowing variation exists in the listed goals from year to year, nurses can be certain they are knowledgeable about current required health care strategies and universal protocols. [Rate your knowledge about the NPSGs.]

Core Measures and Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)

Core Measures (The Joint Commission, 2015) and HCAHPS (2015) are quality initiatives focused on quality patient care and an understanding of what patients really want from providers. Patients want care that is patient-centered, safe, effective, efficient, timely, and equitable. They also want providers who listen without interrupting, are truthful, and explain care clearly and fully. Patients want providers to collaborate with other team members so messages are consistent between the patient and all providers, thus ensuring care will be coordinated and flow smoothly (Anderson, Barbara, & Feidman, 2007).

To ensure consumers’ expectations are met, hospitals are ranked on the process of care (Core Measures) and patient satisfaction (HCAHPS); these rankings are available to consumers. To foster positive rankings, clinical leaders must understand relationships between (a) the Core Measures set and evidence-based care, (b) patient-centered care behaviors and consumer comparisons, and (c) published hospital rankings and financial incentives for hospitals (CMS, 2013). Nurse leaders who are cognizant of HCAHPS patient satisfaction questions will structure care so patients need are met and patient satisfaction is high. Finally, clinical leaders are very aware of the Value-Based Purchasing Program (CMS, 2013) and its relationship to hospital payment for patient care services. [Rate your knowledge about Core Measures and HCAHPS.]

Variations in Practice

Variations in practice, sometimes referred to as fragmented care, can be found at the hospital systems level. The physical design of the organization and the accessibility to updated technology, such as diagnostic equipment and user-friendly medical records, can be sources of fragmented care. Variations can occur as a result of ineffective organizational leadership, the shortage of experienced interprofessional teams, and poor communications among health care providers. Issues related to medical coverage and services (e.g., access to insurance and medical services; high deductibles and co-pays) and the research-practice gap (e.g., lack of organizational culture for research implementation; nurse preparedness and willingness to participate in research) also contribute to fragmented care. Patients are affected by variations in all these dimensions. In addition, variations in practice play a significant role in health care cost. Nurse leaders at the bedside can minimize costs by implementing evidence-based practices and eradicating fragmented care (IOM, 2001).

Clinical leaders at the bedside recognize sources of fragmented care and use structured approaches to eliminate them. These leaders implement evidence-based policies, protocols, and pathways, and share evidence-based and best practices with nurse colleagues. They advo-
cate for the patient’s preferences and values and set the bar high for safe, efficient unit practices (e.g., consistency in care via patient assignments; efficient and effective bedside report processes). Clinical nurses reduce variations beyond the unit by participating in hospital councils, committees, or projects and becoming nurse champions for interprofessional initiatives. They also contribute to the refinement of communication technology, such as inefficient patient care documentation processes (Cook, 2001; Laschinger & Finegan, 2005; Stanley, 2006). [Rate your knowledge about variations in practice.]

Critical Appraisal of Clinical Evidence

In recent years, clinical experts have emphasized the importance of using evidence to guide nursing and medical practice. However, the translation of evidence to practice is relatively slow. Clinical leaders accelerate the process for integrating new clinical evidence into daily practice by learning how to appraise the literature, determine an intervention’s potential for translating into practice, and transition the best clinical practices into patient care (IOM, 2011).

Using the evidence-based process to appraise clinical evidence, clinical leaders guide team members in formulating the research question. They search the literature for current evidence and begin to appraise the evidence by summarizing important elements of research articles in an evidence table. The team then decides if the evidence supporting the new procedure is strong enough to influence clinical practice. If so, members integrate the research evidence with other types of intangible evidence, such as patients’ preferences and values and clinical expertise. The new procedure then is applied in clinical practice and evaluated for its effectiveness. Clinical leaders enhance the translation of evidence into practice by guiding colleagues in use of the evidence-based process to appraise the literature critically and evaluate the need for a specified change in the practice environment (Melnyk & Fineout-Overholt, 2010; Melnyk, Fineout-Overholt, Stillwell, & Williamson, 2010; Polit & Beck, 2014). [Rate your knowledge about critical appraisal of the evidence.]

Practice Environment Core Knowledge

Hospital Systems

Nurse leaders’ source of influence lies in their ability to take actions that improve patient care, enhance patient outcomes, and promote a healthy practice environment. To influence the delivery of patient care services, clinical leaders must understand their hospitals’ structures and their relationship to communication within the organizations. Nurse leaders benefit from knowing about the arrangement of hierarchical management, lines of authority and the chain of command related to decision-making, and the flow of communication from the top down and the bottom up. With this information, clinical leaders can contact specific individuals to whom they can address their concerns or from whom they can seek support for their initiatives (Laschinger & Finegan, 2005; Rao, 2012).

In most cases, delivery of nursing services is guided by a professional practice model. The model is selected based on its fit with the organization’s mission, available resources, and the patient population. Understanding the various practice models fosters selection of the best practice model for the delivery of patient care or, if needed, gives direction to selecting a new model or modifying the current model. Most hospitals select a nursing governance model (e.g., shared governance model) as the framework that empowers clinical leaders to serve on hospital, nursing, and other leadership committees and participate in decision-making related to patient care and work processes (Barden, Quinn, Donahue, & Fitzpatrick, 2011; Bonsall, 2011). [Rate your knowledge about your organization’s structure, culture, and professional practice and governance models.]

Cost Drivers for Nursing Services

Clinical leaders at the point of service are needed around the world to be full partners in redesigning health care. With a basic understanding of hospital revenues and expenses, these nurses are knowledgeable about the cost of patient care and sources of revenue that pay for nursing services. As a result, they can make meaningful suggestions for transforming patient care (CMS, 2013; Nichols & O’Malley, 2006; Quizlet.com, 2014).

Clinical leaders at the bedside are aware of the major components of a hospital’s budget and can identify where the cost of nursing services fits. They are also aware of the four key drivers of nursing care costs: staffing, workload, workflow, and work activities. These leaders can advocate for safe staffing practices because they know patient volume, acuity, skill mix, practice model, and productive vs. nonproductive hours should be considered in determining unit staffing and staffing patterns. They participate in determining workload because they recognize the effect of nurse workload on service quality. Clinical leaders take action to assure efficiency in workflow processes so nurse time and energy are saved and the delivery of quality patient care is ensured. They are also aware of the effect of direct (patient care) and indirect (e.g., change of shift reports, justification of the scheduled drug count, committee meetings) nurse activities on the cost of nursing services. Finally, these leaders recognize the importance of the balance between productivity and quality of services, and its influence on the cost of nursing services. In essence, nurse leaders can integrate knowledge related to the cost of nursing services into work redesign, safe staffing projects, and more (ANA, 2014a, 2014b, 2014c). [Rate your knowledge about cost drivers for nursing services.]

Healthy Practice Environment (HPE)

Optimal patient care does not just happen. Historically, clinical
excellence has been credited as the key to quality patient outcomes. Data indicate the practice environment also plays a significant part in determining patient outcomes. In its report *Keeping Patients Safe: Transforming the Work Environment of Nurses*, the IOM (2004) confirmed the typical nursing practice environment is characterized by many serious threats to patient safety and the existence of an HPE. These threats are found within organization management practices, workforce deployment practices, work design and processes, and the organizational culture. Clinical leaders at the point of service can assist in creating and maintaining an HPE because they know what it is, how to recognize threats, and how to initiate strategies to support it (Aiken, Clarke, Sloane, Lake, & Cheny, 2008).

To create and sustain an HPE, clinical leaders will identify and act to eliminate threats to safety (e.g., ineffective nurse management, inadequate staffing, lack of nurse knowledge and skills, inefficient work processes, unhealthy organizational culture). For example, nurse leaders will approach a colleague who is changing intravenous tubing incorrectly and guide him or her through the correct method. They will support nurses’ participation in decision making related to patient care and work processes on the unit. These leaders know the process for evidence-based change management and will work with the nurse manager and colleagues to ensure the plan for change reflects this approach. Clinical leaders are empowered to speak to nursing administrators about inadequate staffing and high nurse turnover, and their relationship to patient safety and errors. They take action to resolve ineffective work processes, such as inefficient shift reports and excessive or poor use of resources. In addition, they address issues that arise in a toxic organizational culture. For example, a clinical leader will intervene in specific incidents of bullying and work with the nurse manager to eradicate this behavior on the unit. Nurse leaders cannot control the organization’s culture. However, they can promote positive attitudes among colleagues and lead change to improve patient care and support a healthy practice environment (Dearmon et al., 2013; Hall, Doran, & Pink, 2008). [Rate your knowledge about HPEs.]

**Leadership Competency Skills**

Leadership competency skills for nurse leaders at the bedside are grounded in clinical expertise, supported by emotional intelligence, and actualized by expert skills in communication, coordination, and collaboration (the 3Cs).

**Clinical Expertise**

Clinical expertise is based in education, ongoing professional development, training, and clinical experiences, and is enhanced by an attitude of positive thinking and professional values. Clinical leaders approach life with optimism and confidence. Positive thinking is a way of life that is integrated into all aspects of nurse leaders’ lives, professional and private. These leaders’ professional values center on providing the highest level of patient care. As a result, these nurses exhibit a high level of professional integrity and accountability for their work. They are committed to improving nursing practice and patient care. They recognize their professional responsibility to act when issues or problems arise, and they motivate others to act. These clinical leaders have respect for self and others, and their colleagues have respect for them (George et al., 2002; Laschinger & Finegan, 2005).

**Emotional Intelligence**

Leaders must be able to recognize and regulate their emotions and manage those of others. Leaders who do so are said to have a high level of emotional intelligence, which is “the capacity for recognizing our own feelings and those of others, for monitoring ourselves, and for managing emotions in ourselves and in our relationships with others” (Goleman, 1995, p. 317). To manage their own emotions, individuals must have a conscious awareness of their emotions (self-awareness). With this awareness, they can regulate their personal response to the situation (self-management). Social awareness and relationship management emphasize identifying and managing the emotions of others while controlling personal emotional responses. Recognizing and managing the emotions of others allows a nurse leader to handle disruptive or emotional situations effectively. To do so, the clinical leader keeps calm, speaks appropriately, and most importantly, separates the emotions from the individuals. In doing so, this leader manages the group’s relationships by keeping the conversation directed at resolving the issue at hand. In summary, emotional intelligence requires personal reflection and management of personal emotions as well as the ability to listen, observe, process, and negotiate with others during an emotional encounter (Druskat & Wolff, 2001; Goleman, 1995, 1998) (see Table 2 for emotional intelligence skills assessment).

**The 3Cs**

In addition to clinical expertise and emotional intelligence, clinical leaders at the point of service rely on their communication, collaboration, and coordination skills to motivate others to act. Proficiencies in interpersonal (one-on-one) and group communication are the basis for effective coordination of activities and collaboration with others. Interpersonal communication is the critical element for situations, such as coaching/mentoring, educating, managing conflict, and addressing bullying. Expert group communication skills facilitate good group interactions and patient care coordination. These skills also foster interprofessional collaboration that enhances patient care and patient satisfaction. With expertise in the 3Cs, nurse leaders successfully lead committees and manage difficult group situations. In addition, they identify ineffective work processes and motivate colleagues to initiate
change to manage problems, thus improving the delivery of patient care services (Druskat & Wolff, 2001).

A great deal of effort goes into assuring the delivery of patient care is efficient and effective. However, ineffective or inefficient practices can be found in patient care, work processes, and the unit’s organization (see Table 3). In some cases, inefficient practices have been the norm for so long nurses do not recognize the inefficiency. Thus, no action is taken. In other cases, nurses do not want to tackle inefficiencies as they are busy providing patient care; thus they create workarounds. Rather than addressing the problem with nursing managers, these nurses use inefficient methods that may increase the incidence of error (Benner et al., 2008).

Clinical leaders are proactive. Their leadership skills extend beyond addressing ineffective work processes. They can envision a better way to do things. They see the opportunity to improve the status quo and they motivate colleagues

TABLE 2.
Emotional Intelligence Self-Assessment

| 1. Are you able to read other individuals’ feelings and behaviors? |
| 2. Are you able to look beyond the behavior to recognize hidden motivations or agendas? |
| 3. When you experience strong emotions (fear, anger), do you later reflect on the situation that led to the emotion? |
| 4. When you experience strong emotions (fear, anger), do you behave and speak appropriately? |
| 5. When you experience strong emotions (fear, anger), are you able to stay on task? |
| 6. When you experience strong emotions (fear, anger), are you able to separate the cause of the emotion (another person) from the emotion? |

**Note:** The more “yes” responses you have, the higher your level of emotional intelligence.

**Source:** Druskat & Wolff, 2001.

TABLE 3.
Ineffective or Inefficient Practices

<table>
<thead>
<tr>
<th>Patient Care</th>
<th>Work Processes</th>
<th>Unit Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Lack of coordination of patient activities</td>
<td>• Lengthy or poor shift report processes</td>
<td>• Unorganized supply room</td>
</tr>
<tr>
<td>• Non-acuity based assignments</td>
<td>• Disorganized grand rounds</td>
<td>• Inconvenient location of equipment</td>
</tr>
<tr>
<td>• Slow response to call lights</td>
<td>• Nurse retrieval of medications from pharmacy</td>
<td>• Inadequate training re: new procedures, equipment, etc.</td>
</tr>
<tr>
<td>• Inefficient documentation of vital signs</td>
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<td></td>
</tr>
</tbody>
</table>

**FIGURE 2.**
Leadership Competency Skills
Leadership are enhanced patient care, improved patient outcomes and安庆目标的达成。The results of their clinical and patient satisfaction, and the engagement of others in testing innovations. They also envision better ways to deliver patient care services and engage others in testing innovations. The results of their clinical leadership are enhanced patient care, improved patient outcomes and patient satisfaction, and the attainment of a healthy practice environment. Take the challenge! Be a clinical leader at the bedside in your practice environment!

**REFERENCES**


