Chapter 3 : Organizational Climate and Culture

Since the 1960s, health care organizations have systematically responded to economic, social, and financial challenges that have ultimately caused a transformation in health care delivery. Health care organizations now compete in a marketplace based on their ability to demonstrate lean performance, increased efficiency, and quality health outcomes. The payment structure for health care has shifted from fee-for-service to prospective payment to pay-for-performance and outcomes. Further, the landmark Institute of Medicine (IOM) report, Crossing the Quality Chasm (IOM, 2001) described the challenge of care provision in the twenty-first century and detailed the shift that includes moving from provider-centered care to patientcentered care. Inclusion of patient and family values, norms, customs, and need for participation is now a dominant force in treatment decisions. Furthermore, recent inquiry regarding patient safety has emphasized not only patient outcomes, but also the processes and behaviors that lead to safe care. An explosion in information technology capacity is altering the speed and transparency of communication and information delivery. Interdisciplinary care and teamwork are gaining prominence, showing better care outcomes

(Stock et al., 2008). The impact of an impending nurse shortage, the increasing demand for nursing care, and the drive to incorporate evidence-based practice are changing the face of nursing care. Taken together, these issues have transformed health care structure and delivery, creating a fast-paced and ever-changing practice environment for nurses to negotiate. An appreciation for workplace culture is critical for today's nurse leader. In the perfect storm, nurses may wonder how these factors link with culture and their role as nurses and leaders. Nurses' insight into culture enables them to better understand staff behaviors and relationships, norms, change processes, expectations, and communications. This holds true for all levels of nurses from novice to expert practitioner, direct care provider to administrator. This chapter provides an overview of culture, focusing on the factors that affect the culture within an organization also discusses organizational culture and climate and their relationship to the nursing work environment, workforce, and practice. DEFINITIONS Culture Organizational culture is rooted in anthropology, psychology, sociology, and management theory and first appeared in the academic literature in 1952

(Scott et al., 2003). Culture is the set of values, beliefs, and assumptions that are shared by members of an organization. An organization's culture provides a common belief system among its members. The purpose of culture is to provide a common bond so that members know how to relate to one another and to show others who are outside of the organization what is valued. Culture is sometimes likened to an iceberg in that only the top of the iceberg is visible and the invisible part of the iceberg runs deep into the ocean (Daft, 2001). The top of the iceberg can be thought of as being the mission statement, policies, procedures, organizational charts, the way people dress, and the language they use. The invisible part of the iceberg can be what is implicit in the organization, such as the unwritten rules and customs that pervade the work environment (most are easily missed, yet critical to know). Collectively, these variables define the character and norms of the organization. Culture is represented in several ways. For example, the care delivery model that guides nursing practice helps interpret the culture. For example, when a relationship-based nursing care model is used, it represents an underlying belief in patient-centered care. Open visiting hours in the ICU convey the importance of family as partners in care delivery. How new nurses are oriented expresses values about the socialization of new nurses. Many visible aspects of culture reflect the underlying values of the organization. Culture is a multifaceted phenomenon, difficult to comprehend and unravel. The health care system is incredibly complex. High quality health care delivery is dependent upon good communication and collaboration between providers, patients and their families. One way to better understand such relationships is to appreciate how the hospital culture affects nursing units, nursing practice, and patient outcomes. For a nurse to function effectively in an organization, a solid grasp of organizational culture, characteristics, and operations is essential. Culture has been measured both quantitatively and qualitatively. Initially, it was thought that something as diffuse and intangible as culture could only be measured using qualitative techniques. Bellot (2011,
 p. 33) stated that “early culture researchers believed that standardized, quantitative instruments were inappropriate for cultural assessment because they would be unable to capture the subjective and unique aspects
of each culture.” A strictly qualitative approach of cultural assessment can be time-consuming, expensive, and difficult to interpret. Thus various quantitative tools have been developed to more quickly assess culture and allow for comparison across different work environments. In reality, it is likely that a combination of qualitative and quantitative measures are best for capturing organizational culture (Bellot, 2011). The choice of a measurement instrument should be directed by definition, purpose, and context for cultural assessment (Scott et al., 2003). Climate Organizational climate is a concept that is closely linked to the organization's culture and is sometimes confused with it. Although many people use culture and climate interchangeably, the terms are not the same. Climate is an individual perception of what it feels like to work in an environment (Snow, 2002). It is how nurses perceive and feel about practices, procedures, and rewards (Sleutel, 2000). People form perceptions of the work environment because they focus on what is important and meaningful to them. This explains why some aspects of culture may be interpreted differently. Climate can be easier to identify than culture, and so climate refers to the aspects of the work environment that can be measured. Researchers who study climate describe various components of the work environment that influence behaviors (Sleutel, 2000). Some characteristics that are used to study climate are decision making, leadership, supervisor support, peer cohesion, autonomy, conflict, work pressure, rewards, feeling of warmth, and risk (Litwin & Stringer, 1968; Stone et al., 2005). Within organizations, it is common to identify subclimates that focus on very specific aspects of the organizations (e.g., climates related to patient safety, ethics, and learning). Culture-Climate Link Climate research has formed the basis for the definition and research surrounding organizational culture, and the two are closely linked (Bellot, 2011). Regardless of the practice setting, a link exists between culture and climate; and that link is what is important to understanding attitudes, motivations, and behavior among nurses (Stone et al., 2005). The common links between culture and climate can be described as

the interaction of shared values about what things are important, beliefs about how things work, and behaviors about how things get done (Uttal, 1983). Research has shown that, among nurses, culture or climate affects job satisfaction (Hart & Moore, 1989), intent to turnover (Hemingway & Smith, 1999), needlestick injuries and near misses (Clarke, Rockett, Sloane, & Aiken, 2002; Clarke, Sloane, & Aiken, 2002), surgical outcomes (Friese et al., 2008), and patient mortality (Aiken et al., 2008). Nursing Work Group or Nurse Practice Environment Although organizations usually have a single, overarching culture, many climates can exist within that culture, for instance, floor to floor. Groups and organizations exist within society and develop a culture that has a significant effect on how members think, feel, and act. Culture becomes a learned product of the group experience. In general, nurses work together in a group such as on a nursing unit, in home care, in long-term care, or in communities. The nursing unit, or nursing work group, is a small geographic area within the larger hospital system where nurses work interdependently to care for a group of patients. On units, groups of nurses work together, spend time together, and set up their own norms and values and ways to communicate with each other (Brennan & Anthony, 2000). These factors contribute to that unit having its own climate, or perception of what it feels like to work on that unit. Climate is evident in staff perceptions of policies, practices, and goal achievement. Some authors describe this as a work group subculture (Coeling & Simms, 1993). Understanding culture from the unit perspective offers an unprecedented view of nurses' work. The importance of creating an environment with a culture and climate that empowers nurses to practice in ways that support a positive practice environment can maximize nurse and patient outcomes.
BACKGROUND Organizational culture has been studied as both something an organization has and something an organization is (Mark, 1996). Peters and Waterman's In Search of Excellence fueled a renewed business focus on culture as the means to achieve organizational

success and competitive advantage (Peters & Waterman, 1982). Industry leaders in the corporate world quickly realized that the philosophy and values of an organization could determine success and secure market advantage (Wooten & Crane, 2003). The health care industry has been slower than the corporate world to embrace culture as a means to optimize organizational performance. Schein (1996), a renowned sociologist, has defined organizational culture as a shared value system, developed over time, that guides members on how to problem solve, adapt to the external environment, and manage relationships. The mission statement for an organization offers a snapshot of strategic priorities and is an important way to get a sense of organizational values. Schein suggested that a deeper understanding of cultural issues in organizations is necessary not only to understand what goes on but also, more important, to affect outcomes. Organizational culture affects the quality of nursing care and patient outcomes. Shared meanings, the taken-for-granted practice and assumptions of a work unit group, can exert a significant effect on performance and outcomes. Basic underlying assumptions are those that are never questioned and make up an integral part of the fabric of an organization that extends to the unit work level, such as a commitment to excellence and to the surrounding community. Each organizational unit has cultural norms and values that blend the social realities and features that shape interactions among staff, patients, and families. The manner in which the staff perceives organizational culture, manages boundaries, and translates implied values to the unit level has a direct effect on the production of patient care (Alderfer, 1980).
RESEARCH A growing body of research confirms that the relationship between nurse staffing and patient outcomes is influenced by culture or climate and the organizational characteristics of the structure in which nurses practice (Aiken, Sochalski, & Lake, 1997; Mitchell & Shortell, 1997; Needleman et al., 2001; Seago, 2001; Sovie & Jawad, 2001). More recently, studying the impact of culture has shifted from the organizational level to the unit level where caregiver relationships, communication, and autonomy intersect to inform

care decisions that affect individual outcomes. Boyle (2004) found that nurse autonomy/collaboration, practice control, manager support, or continuity/ specialization was significantly related to adverse events. To understand how the culture of the organization and climate of a unit are related to professional practice, three contemporary trends in achieving a culture/climate of quality are discussed here: Magnet Recognition Program®, patient safety climate, and learning climate. Magnet Recognition Program® In 1983, the American Academy of Nursing's Task Force on Nursing Practice in Hospitals studied nursing service best practices by surveying 163 hospitals. The goal was to identify and describe those factors that, when present, created an environment that attracted and retained qualified RNs who delivered quality care. The 41 best hospitals were called “Magnet hospitals” because of their clear ability to attract professional nurses. The 14 characteristics they displayed were identified and called “Forces of Magnetism.” Since 1983, the Magnet Recognition Program has become the gold standard for excellence in nursing. In Magnet-designated hospitals, a strong visionary nurse leader nurtures a professional nursing environment and advocates for, and is supportive of, excellence in nursing practice. Magnet-designated hospitals have been recognized over the years for excellence in patient care, strong nursing practice environments and the ability to attract and retain nurses (ANA, 1997; Kramer & Hafner, 1989). Aiken and colleagues (1994) transformed the initial Magnet hospital work into a program of research congruent with quality of care and organizational effectiveness through study of the links between hospital organizational culture and care outcomes. Magnet hospitals were conceptualized as those institutions that have a specific organizational culture with characteristics of autonomy, practice control, and collaboration. Aiken and colleagues (1994) examined mortality rates in 39 Magnet hospitals and 195 control hospitals using multivariate matched control sampling. Magnet hospitals had a significantly lower mortality rate (4.6% lower) for Medicare patients than that of control hospitals. The Magnet-designated hospitals' cultures provided higher levels of autonomy and control of practice and fostered stronger  professional
relationships among nurses and physicians than did non-Magnet-designated hospitals. Magnet research and an organizational framework developed by Aiken, Lake, Sochalski, and Sloane (1997) provide the means to better understand the link between the unit culture characteristics and adverse events. A nursing unit culture that supports and values nurse autonomy and the provision of adequate resources and effective communication among providers most likely constitutes an environment where practice excellence is the norm. Effects of nursing interventions are mediated by such organizational characteristics at the unit level (Aiken & Fagin, 1997). Magnet hospitals are an example of a positive culture that affects nurse and patient outcomes. Today, Magnet recognition is considered the gold standard for excellence in nursing, although at this time it largely applies only to the acute care, hospital environment (Wolf, 2006). Hospitals wanting to achieve Magnet status must meet the 14 Forces of Magnetism identified by the American Nurses Credentialing Center (ANCC, 2004, 2008). Research that measures the Magnet hospital standards focuses on eight characteristics of an excellent work environment: clinically competent peers, collaborative nurse-MD relationships, clinical autonomy, support for education, perception of adequate staffing, nurse manager support, control of nursing practice, and patient-centered values (Schmalenberg &
 Kramer, 2008). From a broader perspective, Stone and colleagues (2005) developed an integrated
 structure-process-outcome model of relationships among factors describing organizational climate and its effect on outcomes. They identified leadership values, strategy and style, and organizational structure aspects such as communication, governance, and technology as the structural components of climate. Likewise, the process elements of climate include supervision, work design, group behavior, and emphasis on quality that is driven by patient centeredness, safety, innovation, and evidence-based practice. Taken together, these components are likely to have an effect on nurse and patient outcomes. Further, in the journey toward Magnet designation, research and evidence-based practice become important in meeting the core criteria and representing a culture and climate of learning. In a learning culture, the norms and assumptions for learning lead to behaviors that support continuous learning (Daft, 2001). A learning climate is characterized by a shared and positive perception of the value of learning to enhance practice, quality, and outcomes. Cultures in which continuous learning is valued are less likely to become outdated and stale. In the past, it was not unusual to hear nurses say in relation to their practice, “We have always done it this way.” Today, a learning environment encourages nurses to propose new ideas. Moving new research findings into practice has historically taken many years. In a continuous learning culture nurses are challenged to ask, “How can this be done better?” Nurses interact with many patients on a daily basis. Patients are experts about themselves, and nurses are experts about nursing practice. Blending these areas of expertise best positions nurses to ask the question, “How can practice and the environment in which practice occurs be improved?” Nursing practice then becomes a vehicle for generating questions that are important to practice. Culture and group norms can have a profound impact on the shared values that are expressed by nursing staff on individual work units in the hospital setting (Koerner, 1996). The formation of the team at the unit level holds a collective vision for continuous learning. In turn, the norm for learning intersects with the desire for good practice and forms a cohesive unit that shares a value for learning that generates excitement for moving beyond traditional practice. Cultures and climates in which knowledge is freely shared can have a groundswell effect. Examples of outward and visible signs that support nurses' shared values for inquiry include journal clubs, unit presentations, poster displays, and participation in evidencebased research teams. Patient Safety Culture and Climate Since the publication of the Institute of Medicine report To Err is Human: Building a Safer Health System suggesting that 98,000 persons die annually in hospitals because of errors, an emphasis on an organization's patient safety culture and climate has driven both research and change in hospital practices (Kohn et al., 2000). A safety culture is an outgrowth of the larger organizational culture and emphasizes the deeper assumptions and values of the organization toward safety, whereas the safety climate is the shared

perception of employees about the importance of safety within the organization (DeJoy et al., 2004). Like organizational climate, the safety climate has a number of different components including leadership, involvement, blameless culture, communication, teamwork, commitment to safety, beliefs about errors and their cause, and others (Blegen et al., 2005). Safety climate refers to keeping both patients and nurses safe. Strong surveillance skills regarding patients is at the heart of safety. Nurses, who are on the front line of patient care, are in an optimal position to monitor patients to prevent adverse events or near misses of adverse events. The ability of nurses to understand a patient's baseline status and recognize early, critical warning signs or changes in health status is a skill derived from having a strong nursing knowledge base. It is not simply task application. Astute recognition of deviations from normal and timely intervention signify that nurses understand patient baseline status and are capable of intervening to prevent or remediate an adverse event. Knowledge of the patient and the patient's baseline status is derived through subjective, objective, and intuitive observations that are honed as nurses develop a level of expertise in working with specific patient populations. Factors that influence a nurse's ability to watch over patients to avoid errors and adverse events include staffing levels,

 excess fatigue, and lack of education and experience (Hinshaw, 2008). Included in the concept of a safety climate is a focus on nurses' health and safety. Nurses working in hospitals have one of the highest rates of work-related injuries, especially back injuries and needlesticks (Mark et al., 2007). When fewer nurses are working, less help is available to provide care to patients. This results in more work needing to be done in a shorter time and can lead to taking shortcuts, which can result in injury. Regardless of whether the focus of safety is on the patient or the nurse, the likelihood of injury can be lessened where there is a cohesive team. When there is a shared perception among a group of care providers about the value and importance of safety, they are more likely to work together effectively toward common goals. Espousing the values of a safety climate and endeavoring to prevent, detect, and mitigate the effect of errors and injuries increases the likelihood of improved outcomes. As nurses work together as a team, they share information, can anticipate events, and are more likely to respond positively to unanticipated events. One major shift in an organization's safety climate is the move from a punitive and reactive culture to a fair and just culture. Marx (2001) suggested that in a just culture, organizational, individual, and interpersonal learning are balanced with personal accountability and discipline. In a fair and just culture, expectations for system and individual learning and accountability are transparent. Underlying these beliefs, the overall organizational strategy must effectively implement a fair and just culture. When an organization can freely discuss mistakes with the intention of learning from them and when it takes the time and resources needed to understand the mistakes (e.g., root cause analysis), the organizational culture changes from a “blame game” to an environment that is respectful and open to learning (Connor et al., 2007). Within a systems-oriented approach, learning from adverse events can lead to new wisdom and improved ways of doing things. Culture Change in Long-Term Care Following the passage of the Nursing Home Reform Act legislation (OBRA, 1987), a series of quality improvement programs were implemented in nursing homes. By the mid-1990s, the culture change movement had begun to gain popularity. Culture change is distinguished from typical quality improvement activities in its attempt to simultaneously alter multiple aspects of care and caregiving in the nursing home. Culture change is so named because of its aim to adopt an entirely new philosophy in long term elder care; there is no universal operational definition of what specific elements constitute culture change programming. Culture change refers to the movement to reorganize nursing home care completely. Included under this umbrella are several different initiatives that address staff, resident, environmental, or behavioral outcomes or some combination of these factors. Most culture change initiatives are focused upon resident-directed care, providing services that are directed by the strengths and preferences of the individual resident. Some research has been done to evaluate various culture change initiatives; however, some models have

been promulgated and replicated more than others. Lustbader (2001) noted that early culture change initiatives, although generally dedicated to the same principles of resident-directed care and homelike social structures, were unique from nursing home to nursing home. Despite the wide range of programming, Shields (2004) stated that nursing homes that have engaged in culture change activities report less staff turnover, a stable administration and full occupancy. In 1995, at a meeting of the National Citizens' Coalition for Nursing Home Reform (NCCNHR), a panel of administrators whose nursing homes were engaged in culture change initiatives was convened. This group grew in size and strength and became known as the Pioneer Network. Today, the Pioneer Network is an organization of facilities engaged in many diverse culture change initiatives, dedicated to a common set of values. These values include returning the locus of control to residents, enhancing the capacity of frontline staff to be responsive, and establishing a homelike environment (Lustbader, 2001). Some of the most prominent culture change models include the Eden Alternative, The Green House Project, and the Wellspring Program. Development of a new model or culture change must be preceded by comprehensive assessment of the unit culture, an understanding of the patient population, what members of the staff need to care for them, and what roles are required to form the unit team. There is no one right model, nor does one size fit all settings. The work entails a deliberative process to facilitate change that will improve outcomes. Culture development must be an essential component of any new culture change. Transparency and frequency of clear communication is critical for cultural transformation and buy-in from all staff.

LEADERSHIP AND MANAGEMENT IMPLICATIONS Culture is characterized by complexity and is relatively enduring, making it hard to change. Climate, on the other hand, can be easier to change. Regardless, the basic elements that constitute culture and climate must be understood before any change. Change that begins at the unit level may be most influenced by nursing leadership. Nurses have the ability to create or change a work culture or climate to accomplish a change that may affect productivity, satisfaction, and safe, high quality, patient-centered care. The role of a nursing leader is to influence culture and the climate. A primary task of the leader is to create a convincing vision that inspires and engages the entire team to move it forward. Values drive behaviors. The leader communicates this vision by influencing norms and values and creating a shared perception through role modeling and ensuring role clarity, accountability, and a nurse practice environment that promotes safe, patient-centered care. Nursing unit leadership is key to creating a positive unit climate that promotes effective unit functioning and quality care (Sorrentino et al., 1992). Unit-based nurse managers serve as bridges between the senior nursing leadership and direct care nursing staff. By virtue of their position, nurse managers are instrumental in shaping and managing the core values of their staff (Anthony et al., 2005). “Nurse managers have multiple and competing demands that they must balance in defining, prioritizing, and implementing their role responsibilities to meet the goals of the organization as well as those of the profession” (Anthony et al., 2005, p. 146). Increasingly, studies are showing that the nurse manager is important in retention (Anthony et al., 2005; Boyle et al., 1999; Taunton et al., 1997), professional practice (Manojlovich, 2005), and work environments (Upenieks, 2003). However, this influence is diluted when nurse managers are managing too many units or across too many areas and need to create and support a climate unique to each practice environment (Kimball & O'Neill, 2002). Key areas within the leader's scope of control are recruiting and retaining staff, welcoming new staff, providing orientation, celebrating and recognizing staff accomplishments, facilitating change, and promoting a learning environment. Climate is evident in how policies are enacted, unit norms, dress code and appearance, environment, communication, and teamwork. The nurse manager can articulate the vision, mission, and goals of the organization and work with staff to translate them into unit-level values for performance, thus linking the context of the organization to clinical practice. Values drive the way resources are distributed. They contribute to a general attitude and sense

about the quality of working life and reflect the

 organization's core goals. Clues can be gleaned from organizational documents such as philosophy statements and meeting minutes. Caring values of the organization are reflected in the way the organization treats its staff. Organizational values may not mirror professional values. The leader's role is to bridge such values with the values of individual team members to construct individual unit climate. Values support the mission and the related vision, which, in turn, support strategies and action plans. The key platform is shared values. Given the complexity and diversity of the nursing workforce, developing and sustaining a set of shared values is no easy task and requires leadership skill. Leaders are expected to chart a clear course for change and mobilize staff to accomplish organizational goals. This means implementing change effectively. Effective cultural change requires communication, passion, and sense of the whole. The nurse manager can create such opportunities through using focus groups, holding team meetings, coaching and mentoring, posting minutes from staff meetings, consulting communication books, and empowering staff by soliciting their input. The value of

 communication cannot be overstated. Much of the work is common sense, but the importance of doing this work lies in carefully attending to the basic change process as a way to avoid the need for damage control later. Peters and Waterman (1982) stressed that the greatest professional need people have is to find meaning in their work life. The job of managers is to help create meaning through the use of stories, slogans, symbols, rituals, legends, and myths that convey the values, beliefs, and meanings shared among the staff. Managers should function as passionate leaders to motivate staff. The challenges of leadership belong to every nurse, not just those in formal administrative or management roles. Leadership at the staff level may simply take a different form. For example, a staff nurse adapting to a challenging patient assignment, taking initiative to change practice through performance improvement, or challenging the status quo is participating in unit culture construction. Further, staff nurses are critical to founding and maintaining a Magnetdesignated organization. Implications Nurse leaders with an accurate and comprehensive assessment of culture and climate can identify strategic target areas for change. A thorough understanding of organizational culture and climate is a powerful diagnostic tool that may be used to identify both troubled and high-performance areas. An effective organizational culture empowers nurses to practice fully within the scope of their knowledge and education. The culture of a nursing unit practice environment may exert a significant and independent effect beyond that of staffing and skill mix by enhancing or impeding interventions once problems are detected. Nurses serve as the surveillance system for early detection of adverse events. The number of nurses may have less influence on patient outcomes than the organization and structure of the work environment itself, including the perceived level of autonomy, the amount of control over their practice, and effective collaboration with physicians (Aiken et al., 2001; Sochalski et al., 1999; Sovie & Jawad, 2001).

CURRENT ISSUES AND TRENDS At the beginning of the chapter, a number of forces were identified that have had significant influence in changing the culture of health care delivery. Several of these forces have particular impact on nursing care, and a brief discussion of patient- and family-centered care, generational diversity and the Quality and Safety Education for Nurses (QSEN) initiative follows to exemplify current issues and trends related to organizational climate and culture. Patient-Centered and Family-Centered Care The Institute of Medicine's Crossing the Quality Chasm (2001) has identified that the culture of patient care must transition from care that is driven by providers to care that is patient-centered and family- centered in which patient and family norms, values, and preferences are respected. The National Healthcare Quality Report from the Agency for Healthcare Research and Quality (2002) defined two aspects of patient-centered care: the patient experience and patient partnerships. The patient's experience of care includes communication, care, and understanding of the meaning of his or her illness. This approach changes the focus from a patient with a disease to that of an individual with an experience. Patient partnerships, the second dimension of patient-centered care, are formed when nurses are responsive to patient needs, values, and preferences and then customize the care to the patient. For example, when performing discharge teaching, information that is of high importance and value to the patient is addressed first in a patient-centered model of care. As patient advocates, nurses can be leaders in transitioning an organizational culture from provider-driven care to care that is truly patient-centered. Generational Diversity and the Nursing Shortage The importance of a positive work climate on organizational, patient, and nurse outcomes is firmly established and evidence-based. However, creating a work environment for nurses that meets their personal and professional values can be a challenge. In 2008, for the first time since the inaugural National Sample Survey of Registered Nurses, the number of nurses working who were under age 30 years and over age 60 years were almost equal (U.S. Department of Health and Human Services, 2008). Because nurses from each of these generations were raised with a different set of priorities and values, a work environment supportive to each generation is an important retention strategy. For example, baby boomer nurses value rewards. Recognition and pay may be motivators for them. In contrast, Generation X nurses are concerned with a better balance of work and life (Duchscher & Cowin, 2004). Tailoring the work environment to meet generational and life-stage needs is a recurrent theme in being able to successfully address the impending nursing shortage. Quality and Safety Education for Nurses (QSEN) In 2005, a joint project of the Robert Wood Johnson Foundation and the National League for Nursing, called the Quality and Safety Education for Nurses (QSEN), was announced. The purpose of QSEN is “to address the challenge of preparing future nurses with the knowledge, skills and attitudes necessary to continuously improve the quality and safety of the healthcare systems in which they work” (QSEN, 2012, p. 1). Widespread rollout of the QSEN program has resulted in extensive nursing faculty education that is designed to create nursing curriculum that emphasizes organizational culture attributes such as the implementation of patient-centered care, emphasis on teamwork and collaboration, integration of evidence-based practice and creation of a culture that supports quality improvement, safety, and informatics. To this end, QSEN key tenets are geared toward teaching nursing students the competencies they will need to affect organizational culture and create an environment that maximizes patient safety and health outcomes. By incorporating these elements into nursing education, it is believed that nurses will enter the workforce with the tools necessary to help create an organizational culture that fosters high quality nursing care. QSEN has now expanded to target nurses both prelicensure and at the advanced practice level. This initiative is an example of how to make large-scale cultural change in nursing.