Charting the Course: Developing QSEN Competencies in Graduate Education

2011 QSEN National Forum Pre-Conference
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Presenters

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- Monica S. Scheibmeir, PhD, ARNP, FAANP, Dean, School of Nursing, Washburn University, Topeka, KS

- Kate Fiandt, DNS, APRN, FAANP, Professor & Associate Dean for Graduate Programs and Clinical Affairs, School of Nursing, University of Texas medical Branch, Galveston, TX
Quality and Safety Education for Nurses (QSEN)

• Long-Range Goal
  ◦ To reshape professional identity formation in nursing so that it includes commitment to the development and assessment of quality and safety competencies

• 2005-2007 focused on undergraduate, pre-licensure competencies

• 2007-2009 focused on graduate competencies
QSEN Graduate Education

Initial conversation:

- Focus on advanced practice rather than all advanced roles or type of program in which student is prepared
- Focus on assisting faculty who wish to develop quality and safety competencies already identified as essential elements
QSEN Phase I: Graduate Education

- Sought feedback from major APN organizations about KSAs: Can they represent all of nursing?
- Added NONPF representative to Advisory Board and included other members in various meetings
Graduate Education Workshop
Topics

- Are the prelicensure competency definitions relevant to APRNs? All of nursing?
- Which of the prelicensure KSAs are also relevant objectives for APRN education?
- What new KSAs, if any, should be added at the graduate level?
- Will KSAs vary by specialty and role or can they encompass all APRNs?

- The competency definitions are relevant to APRN as well as pre-licensure students
- The KSAs can represent all specialties but some needed enhancing
NONPF’s Commitment to Quality and Work of QSEN

- Four roles of APRNs may also address competencies; NONPF focused on NP education
- NONPF’s mission is to advance quality NP education
- Participation in QSEN project prompted NONPF to re-examine its CORE and DNP competencies to insure we were addressing the full scope of quality
- NONPF leadership supported the QSEN framework
NONPF’s History with Quality Education and Competencies

- **2002-2003** NONPF facilitated a National Panel to develop the Psychiatric-Mental Health Nurse Practitioner Competencies

- **2003-2004** NONPF facilitated a National Panel to develop the Acute Care Nurse Practitioner Competencies

- **2005-2006** NONPF developed the Practice Doctorate Competencies using a National Panel consensus model

- **2011** Combined NONPF Core Competencies and DNP Competencies
QSEN Cross Mapping with NONPF Core and DNP Competencies

- Funded by QSEN and NONPF
- Task Force met in DC September 10, 2008
- Cross mapped all QSEN competencies (Knowledge, not Skills and Attitudes) with NONPF Core Competencies and DNP Competencies
NONPF Task Force Members

- Michelle Beauchesne, Northeastern U
- Margaret Brackley, University of Texas HSC San Antonio
- Shirley Drayton-Brooks, Widener University
- Kate Fiandt, University of Texas Medical Branch
- Carol Savrin, Case Western Reserve U
- Monica Scheibmeir, Washburn University,
- Joanne Pohl, Chair, University of Michigan
- NONPF Staff Liaison: Kitty Werner
- Guest: Linda Cronenwett, QSEN, University of North Carolina Chapel Hill
FOUR Components Regulation (LACE)

- Licensure
- Certification
- Education
- Accreditation
Process for Cross Mapping

- **NONPF Core Domains (75)**
  - Management of patient health/illness status
  - NP-Patient relationship
  - Teaching coaching
  - Professional role
  - Managing/negotiating healthcare delivery system
  - Promotes healthy environments
  - Culturally sensitive care

- **NONPF DNP Competencies (24)**
  - Independent Practice
  - Scientific Foundation
  - Leadership
  - Technology & Information Systems
  - Policy
  - Quality
  - Health Delivery System
  - Practice Inquiry
  - Ethics

**QSEN (Knowledge)**

- Patient-centered care
- Evidence-based practice
- Safety
- Teamwork & Collaboration
- Quality improvement
- Informatics
**Example of Cross Mapping**

**Table 1. Patient-centered Care**

Definition: Recognize the patient or designee as the source of control and full partner in providing compassionate and coordinated care based on respect for patient’s preferences, values, and needs.

<table>
<thead>
<tr>
<th>QSEN APRN Knowledge</th>
<th>Where captured in NONPF Master’s and DNP Core Competencies</th>
<th>If not in Core, should it be; if so, where would it fit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Analyze multiple dimensions of patient centered care:</td>
<td>Domains 1 and 2</td>
<td>“coordination” is implied but not specified</td>
</tr>
<tr>
<td>• patient/family/community preferences, values</td>
<td>Domain 7, #24, 26, 36-41</td>
<td></td>
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<tr>
<td>• coordination and integration of care</td>
<td>Leadership, #1-3</td>
<td></td>
</tr>
<tr>
<td>• information, communication, and education</td>
<td>Practice Inquiry, #1</td>
<td></td>
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<tr>
<td>• physical comfort and emotional support</td>
<td></td>
<td></td>
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<tr>
<td>• involvement of family and friends</td>
<td></td>
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<tr>
<td>• transition and continuity</td>
<td></td>
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<tr>
<td>Analyze how diverse cultural, ethnic, spiritual and social backgrounds function as</td>
<td>Domain 1, #7, 8, 14</td>
<td></td>
</tr>
<tr>
<td>patient, family, and community values</td>
<td>Domain 4, #54</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Domain 7, #70-75</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Health Delivery System, #4</td>
<td></td>
</tr>
<tr>
<td>Analyze social, political, economic, and historical</td>
<td>Domain 5, #60, 63</td>
<td></td>
</tr>
<tr>
<td>dimensions of patient care processes and the implications for patient-centered care</td>
<td>Policy, #1</td>
<td></td>
</tr>
<tr>
<td>Integrate knowledge of psychological, spiritual, social,</td>
<td>Domain 2, #26, 28</td>
<td></td>
</tr>
<tr>
<td>developmental and physiological models of pain and suffering</td>
<td>Domain 7, #73</td>
<td></td>
</tr>
<tr>
<td>Analyze ethical and legal implications of patient-centered care</td>
<td>Domain 1, #21</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Domain 4, #43, 52</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Domain 5, #58, 61</td>
<td></td>
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<tr>
<td></td>
<td>Domain 7, #70</td>
<td></td>
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<tr>
<td></td>
<td>Policy, #1</td>
<td></td>
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<tr>
<td></td>
<td>Ethics, #1</td>
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</tbody>
</table>
**Example: Patient Centered Care**

<table>
<thead>
<tr>
<th>QSEN APRN Knowledge</th>
<th>Where captured in NONPF Master’s and DNP Core</th>
<th>Gaps in NONPF Competencies</th>
</tr>
</thead>
</table>
| Analyze multiple dimensions of patient centered care: patient/family/community preferences, values coordination and integration of care information, communication, and education physical comfort and emotional support involvement of family and friends transition and continuity | Domain 1: Management of Patient Health/Illness Status  
(1) Provides health promotion services  
(2) Provides disease prevention services  
Domain 2: NP-Patient Relationship  
(26) Attends to the patient’s responses to changes in health status and care **DNP:**  
Leadership,  
(1) Assumes increasingly complex leadership roles  
(2) Provides leadership to foster interprofessional collaboration | “coordination” is implied but not specified |
## Example: Quality Improvement

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| Analyze the differences between micro-system and macro-system change | **Domain 5: Managing and Negotiating Health Care Delivery Systems**  
(60) Analyzes organizational structure, functions, and resources to affect delivery of care  
(63) Evaluates the impact of the health care delivery system on care.  
(65) Advocates for policies that positively affect health care | Need more on system change in Master’s core |
| Understand principles of change management | **Domain 5: Managing and Negotiating Health Care Delivery Systems**  
(66) Negotiates legislative change to influence health care delivery systems  
**Domain 6: Monitoring and Ensuring the Quality of Health Care Practice**  
(69) Engages in continuous quality improvement | Gap in Master’s core |
## Example: Informatics

<table>
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<tr>
<th>QSEN APRN Knowledge</th>
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<th>Gaps in NONPF Competencies</th>
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</table>
| Contrast benefits and limitations of common information technology strategies used in the delivery of patient care | Domain 4: Professional Role  
(53) Incorporates current technology  
DNP Core  
Technology & Information Literacy,  
(1) Demonstrates information literacy in complex decision making  
(2) Translates technical and scientific health information appropriate for user need  
(3) Participates in the development of clinical information systems | Generally beyond Master’s core. Needs emphasis but better said and addressed in DNP Technology & Information Literacy. |
| Evaluate the strengths and weaknesses of information systems used in patient care | Domain 1: Management of Patient Health/Illness Status  
(24) Communicates effectively using professional terminology, format, and technology | Generally beyond Master’s core.                                                        |
Results of Cross Mapping
Published in *Nursing Outlook, December, 2009*

- Overall NONPF Core and DNP competencies have Q & S competences embedded
- NONPF competencies do not have the depth or clarity of QSEN competences
- Gaps identified especially in areas of systems and informatics,
- A robust integration of QSEN KSAs into current curricula is consistent with NONPF’s emphasis on safety and quality in their Core and DNP competencies.
- QSEN Knowledge objectives are not an add-on in terms of new courses, but require new and creative ways of teaching

## Summary of Cross Mapping

<table>
<thead>
<tr>
<th>Strong Areas of Agreement</th>
<th>Some Gaps</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient-centered care</td>
<td>Systems</td>
</tr>
<tr>
<td>Collaboration</td>
<td>Informatics</td>
</tr>
<tr>
<td>Teamwork</td>
<td>Interprofessional Teams</td>
</tr>
<tr>
<td>Evidence based care clear in DNP competencies</td>
<td>Cross mapping consistency may not be evident to those not part of the process</td>
</tr>
<tr>
<td></td>
<td>Depth of safety in NONPF competencies not as evident as it could be</td>
</tr>
</tbody>
</table>
NONPF Task Force: Additional Work on KSAs: Update August, 2009

- Task Force met again in DC with QSEN director, Dr. Linda Cronenwett
- Distinction between QSEN and NONPF Core Competencies is depth and comprehensiveness related to quality and safety
- Decision to focus on skills believing that if knowledge & skills were addressed, attitudes would follow
- Belief that many faculty may not have the skills to teach and evaluate quality of care in depth
Presented Teaching Strategies at NONPF Annual Meeting 2010

- Handling Adverse Patient Outcomes
- Quality Improvement
- Peer Review
Teaching Strategy 1: Handling Adverse Patient Outcomes
M. Scheibmeir

- QSEN Competency: Patient Safety
- QSEN Competency: Quality Improvement
Medical Errors are:

- Common
- Result in human morbidity and mortality
- Often avoidable
Types of Medical Errors

- Adverse Event
- Medical Error
- Serious Error
- Minor Error
- Near Miss
Types of Medical Errors

- Diagnostic
  - Error in delay in diagnosis
- Treatment
  - Error in performance of choice of treatment
- Preventive
  - Failure to provide preventive treatment or follow-up
- Failure in Communication
- Equipment Failure
Errors

...since doctors do not discuss their mistakes, they do not know how other physicians cope with them. The drastic consequences of errors, the repeated opportunity to make them, ...and the professional denial that mistakes happen, create an intolerable dilemma for them.

Resolving Errors Requires

- Education
- Fail-safe Systems
- Carefully implemented Patient-Safety Policies
Types of Reporting Mechanisms

- Mandatory
- Voluntary
- Anonymous
- Confidential
- Active Spontaneous
- Passive
Clinical Scenario

• 23 year old male who presents with laceration to his forehead
• **HPI:** Hit his head when wrestling with his 3 year old son, No LOC
Clinical Scenario

- 23 year old male who presents with laceration to his forehead
- HPI: Hit his head when wrestling with his 3 year old son, No LOC
Clinical Scenario

• **PMH:** NKDA, in generally “good health”.

• **PE:** ~3cm laceration over the lateral aspect of the right eyebrow-no eyelid involvement

• **PE:** No **bruising** at the site of the laceration.

Wound edges somewhat jagged.
Clinical Scenario

- Wound was irrigated.
- Cosmesis was obtained with non-absorbable simple interrupted sutures- minimal blood loss.
- Tetanus status review
- Instructions for follow up re: wound care, suture removal and s/s infection.
Clinical Scenario

• Pt. returns ~24 hours later with s/s wound infection (erythema at wound site with swelling, no visual impairment, no neurological changes)

• No s/s of systemic illness secondary to infected wound
Adverse Event Cascade

- Sutures removed
- Cultures obtained from wound site
- ENT physician consulted
- 72 hours of out-patient IV antibiotics
- 3 days of interrupted wages for the pt.
Organizational Response to Adverse Event

- Chart review by provider revealed that clinic RN had indicated the pt. reported that his “three-year-old’s mouth hit his forehead when they were wrestling”.
- Provider called the physician owner of the urgent care clinic to discuss the case.
- Family physician calls NP to discuss case
Organizational Response to Adverse Event

- Protocol for Wound Management
- Review of high demand times in the Urgent Care
- Revised weekend schedule to accommodate increased numbers of patient visits.
Using Errors in the Advanced Health Assessment Course

- Integrated incident into the lecture on the importance of history-taking
- Discussed the details of the history section of the patient encounter
- Described the error in detail to students
Using Errors in the Advanced Health Assessment Course

- Discussed importance of open-ended questions in eliciting the HPI
- Risks associated with being rushed in an encounter
- Tips on how to avoid making history-taking errors
- Reinforcing QSEN competencies of Patient Safety and Quality Improvement
Project #2 Quality Improvement
Kate Fiandt

QSEN Competencies:
- Primary Competency: Quality Improvement
- Secondary Competencies: EBP and Teamwork and Collaboration
Quality vs safety

- Safety is necessary but not sufficient
- Little data about safety in ambulatory settings
- Extensive data about quality in ambulatory settings
Quality in Primary Care

- Rand (2003)
  - < 55% received recommended preventive care
  - < 60% received recommended chronic care
  - Variation: 78% senile cataracts treated to standard, 10% alcohol dependence treated to standard

- Commonwealth Fund (2008)
  - Patient centered care: Less than 50% of patients could get rapid appt when ill. In addition, 73% couldn’t get after hours care without going to an ER
  - Efficiency: 3-4 x benchmark rate of patients report duplicate tests or medical records not available at visit

- AHRQ (2008)
  - 28% Hispanics uninsured all year while < 10% White Non-Hispanic
  - 14% of low income patients reported problems with communication at a health care visit compared with 8% of high income patients
Gaps re: Quality

• Primary Care Education
  – IOM Recommendation

• Ambulatory Settings
  – Limited safety data

• Vulnerable Populations
  – Know disparities, need more work on eliminating disparities
Objectives

- Objectives: At the completion of this project the student will have demonstrated:
  - An understanding of the issues surrounding quality and safety in primary care settings
  - An ability to identify and document a problem with quality in a practice setting
  - The ability to lead change to improve quality in a practice setting
  - The ability to collaborate across practices with to improve care delivery in one area of quality
Key Assumptions

• Students are able to stay in a practice over time (2-3 semesters)
• May do as individual or small group (comparing practices)
• The practice supports and participates in the process
• The learning activity builds on foundation content from research and evidence based practice
• Ideal for DNP capstone or MSN “research” project
Semester One: Activities

- Students identify a group of 4-5...using a traditional QI collaborative model
- Identify population of interest
- Prepare and conduct audits to identify baseline data
- Concurrently they receive 3-4 hours of initial content on practice improvement
  ..sufficient to provide an overview and the knowledge and skills to conduct the first portion of the project
Audits

- Students develop an audit tool and receive faculty feedback
- Collect data to support current status of aim topic in their practice
- Compare data across practices
- Establish benchmarks
Semester One: Example

- Four FNP students in family practice settings
- Choose patients with type 2 diabetes
- Choose “annual foot checks” as issue
- Conduct chart audit of 40 patients with type 2 diabetes/practice...% of patients with documented foot check in last year...this establishes baseline
- Aim – 100% of patients with type 2 DM will have a foot check documented in chart in last year
Semester One: Example

- At baseline % of patients with documented foot check
  - Practice #1 = 70%
  - Practice #2 = 30%
  - Practice #3 = 35%
  - Practice #4 = 50%

- As a collaborative, at this point the students work together and ask:
  - what is practice #1 doing different?
  - what are some possible interventions to improve outcomes?
% T2D Patients with Documented Foot Check in last 12 Months
Semester One: Evaluation

• Group presentation:
  ◦ Audit tool and process – lessons learned
  ◦ Data collection – data
  ◦ Describe the benchmark they have chosen and the rationale (and source) for the benchmark (e.g. national guideline or PQRI benchmark)
Semester Two: Activities

- Students meet as group and explore possible interventions
- Students meet with the staff at their practice and explore possible interventions
- Conduct rapid improvement cycles (PDSA)
  - At least 2 plan-do-study-act cycles in each practice
- Concurrently receive didactic content on doing PDSA cycles and on evidence based practice (reinforcement from formal course)
Semester Two: Example

- Signs in room – “if diabetic take off shoes”
- In-service, train support staff to do exams
- Put foot check form in each chart
- Put ADA diabetes flow sheet in each chart
Semester Two: Evaluation

- Individual students submit their write-up of at least two P-D-S-A cycles
- Group report:
  - Literature on evidence based interventions specific to address the problem
  - Rationale for the interventions chosen
  - Lessons learned from the process of implementing the improvement process
Semester Three: Activities

- Evaluate impact of interventions
- Didactic content (2-4 hours) on evaluation of projects and presentation of data (e.g. trend charts)
Semester Three: Example

- **Comparison of practices**
  - Practice # 1 from 70% to 80%
  - Practice # 2 from 30% to 60%
  - Practice # 3 from 35% to 50%
  - Practice # 4 from 50% to 80%

- **Analysis of process:**
  - What worked and what didn’t
  - Gaps in literature
  - Lessons learned
% T2D Patients with Documented Foot Check in last 12 Months

Baseline

12 months

- Practice 1
- Practice 2
- Practice 3
- Practice 4
Semester Three: Evaluation

- Group report:
  - Presentation of data
  - Analysis of process
Teaching Strategy 3: Peer Review
J. Pohl

- QSEN Competencies addressed with this strategy
  - Patient-centered Care
  - Evidence Based Practice
  - Safety
  - Team and Collaboration
Exemplar: Peer Review with ANP and FNP Students in their Final Year

- Providing a safe environment and culture that promotes quality and safety

- Peer review is a critical aspect of professional practice and development as well as a component of quality improvement.
What Peer Review IS & is NOT

- Not solely evaluation
- Is an opportunity to reflect on your insights into your practice and your peers’ practice
- Opportunity to link care with conceptual model of care & evidence based practice
- An opportunity to examine system issues versus “good and bad apples” in quality and safe care
- An opportunity for transparency and risk taking
- Opportunity for participants/reviewers to develop skills in providing thoughtful feedback
Turning Evaluation Upside Down

- Students are evaluated on their ability to share a difficult clinical situation versus a pearl—including errors, missed diagnoses, disagreements with a preceptor’s management of a problem, ethical issues, situations where they felt “uncomfortable”, reflective practice.

- Students are evaluated on their ability to give critical feedback to their peers in a thoughtful professional manner.
Placement of Peer Review in Curriculum

- Placement in final clinical year near end of program is essential
- Requires mature role development
- Able to focus on ambiguity and complexities of advanced practice
- More comfortable with clinical skills and able to focus on larger issues including errors, conflict, and systems issues
Examples Students Have Presented

- Disagreeing with a preceptor’s decision regarding management of a patient; not evidence based;
- ED: Patient without insurance who had been robbed at gun point, presented with PTSD symptoms and ER staff blew off as a “typical” psych patient;
- Student who thoroughly reviewed an adolescent record with frequent visits over years before seeing patient and alerted physician preceptor that patient had never been seen alone without mother; with support from physician informed mother she would like some time just with the patient;
- Adolescent risky health behavior (unprotected sex; recurrent STIs; substance use);
- Evidenced based care when patient has no insurance to cover testing, medications, etc;
- Over prescribing of controlled substances by preceptor;
- Competent care for the transgendered patient.
KSAs: Attitudes Linked with this Strategy (Examples)

- Patient Centered Care
  - Value the process of reflective practice
  - Value system changes that support patient-centered care
  - Respect patient preferences for degree of active engagement in care process
  - Honor active partnerships with patients or designated surrogates in planning, implementation, and evaluation of care
  - Seek to understand one’s personally held attitudes about working with patients from different ethnic, cultural and social backgrounds
  - Value cultural humility
  - Value seeing health care situations ‘through patients’ eyes’
Attitudes

Safety

- Appreciate the cognitive and physical limits of human performance
- Value own role in reporting and preventing errors
- Value systems approaches to improving patient safety in lieu of blaming individuals
Attitudes

- Teamwork & Collaboration
  - Acknowledge own contributions to effective or ineffective team functioning
  - Respect the centrality of the patient/family as core members of any health care team

- Evidence based practice
  - Appreciate strengths and weaknesses of scientific bases for practice
  - Value the need for ethical conduct of research and quality improvement
  - Value all components of evidence-based practice
  - Acknowledge own limitations in knowledge and clinical expertise before determining when to deviate from evidence-based best practices
  - Value the need for continuous improvement in clinical practice based on new knowledge
WHAT STUDENTS SAY

- “We were able to acknowledge our strengths and weaknesses.”
- “Aware that other students and faculty struggle with the same issues of complexity of practice.”
- “It validates what I learn in the classroom.”
- “I understand the system issues challenging quality care more than ever”
- “It has helped me understand the depth of practice issues; I could not have done this (Peer Review)in my first year.”
- “The safe environment facilitated sharing risky questions.”
- “Wish we had more opportunities for such experiences.”
- “This helped me “pull it all together.””
SUMMARY
NP Integrated Core Competencies

JUST RELEASED APRIL, 2011

Have addressed some gap areas
Available on NONPF website

http://NONPF.org
References & Handouts

• **References**
  

• **Handouts**
  - Fiandt presentation: Resources
  - Pohl presentation: Peer Review form

• **QSEN Website:** [http://www.qsen.org/](http://www.qsen.org/)