IMPLEMENTING QSEN: CHALLENGES & OPPORTUNITIES

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FOCUS OF PRESENTATION

- Objectives
  - Present results of faculty survey on implementing QSEN
  - Discuss changes and barriers that were identified
  - Identify the strategies that have/can be used to train nursing faculty
SURVEY

- n = 19 (35 full & part time faculty)
- 10 questions with fixed response or essay format
- Online anonymous format using Survey Monkey
SURVEY RESULTS

- **Question 1** – knowledge of QSEN resources
  - 68.4% = 13 were aware of QSEN

- **Question 2** – discuss resources used (only 15 answered the question)
  - 2 faculty not aware of QSEN
  - staff work arounds
  - simulation strategies
  - safety & EBP materials,
  - reviewed KSAs
  - case studies
SURVEY CONTINUED

- Courses where faculty are making plans for the future
  - Pathophysiology medical/surgical nursing course
  - Advanced practicum in MSN program
  - Simulation
  - Public health
  - Integrated theory/practicum
  - Leadership practicum
  - Fundamentals
CHALLENGES

- TIME
- Understanding best teaching strategies
- Need more education about QSEN
- Development of assignments
STRATEGIES

- Picked theory & clinical leadership course as pilot
- Reviewed current assignments to evaluate how and where to incorporate QSEN competencies
- Revised schedule & assignments so that each week students would understand which competency was the focus for that week
STRATEGIES

- Include the IHI leadership modules as an assignment for the theory class
- Class discussion examples – IHI forgotten team member, assignment on providing care through teamwork and collaboration (Pam Ironside), IHI human factors exercise
- Incorporated a quality and safety assignment using staff workarounds (Lisa Day) as the topic into both the online theory course (paper assignment) and the on campus course (group poster assignment)
Who’s Counting Anyway?
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What is the policy and procedure?
Counts should occur at the following times:
- At the beginning of a procedure, before the first incision
- Any time a new package of equipment is opened
- Closing a cavity within a cavity
- When a staff member is permanently relieved from the case
- A final count before the patient is closed

Items in the count:
- All pre-packaged instrument sets, cutting instruments, forceps, clamps, retractors, needle holders, suction equipment, gauze, sponges, lap sponges, cotton balls, and needles
- Items should be counted in the same sequence every time
- Staff involved in the count:
  - A final count before the patient is closed
  - Verbal confirmation by the surgeon that the count is correct
  - Counts are done audibly and viewed by two people
    - (one of which should be an RN)
  - Verbal confirmation by the surgeon that the count is correct

What were the observations?
We observed that in multiple surgeries, operating room staff skipped several different steps in the counting procedure.
- Counts were recorded on a piece of paper rather than designated counting white board
- The final count was done and recorded while the patient was being closed
- Two staff members were present and they both audibly confirmed the count, but only one was visualizing the count
- Doctors did not give verbal confirmation of the final count

What is the issue?
Despite multiple counts throughout surgery by operating room personnel, foreign objects are left behind in 0.3-1 per 1,000 surgeries (NIH, 2009). Retained surgical equipment can lead to a number of problems, including pain, infection, obstruction, perforation, tumors, multiple surgeries, and death. The surgeon is ultimately responsible for preventing these occurrences; however, the actual task of counting instruments is delegated to nurses and other operating staff. Best practice recommends that surgical counts occur before the procedure to establish an initial count, again when new instruments are added to the field, and lastly at wound closure. Although the potential for retained foreign objects exists with any surgery, this risk is increased when there are deviations from hospital policy and procedure.

Why are there deviations from policy?
We informally interviewed several RNs working in the operating room.
Some of the common responses were:
- The extensive policy was repetitive
- Time restraints due to increased case load
- “Recounting of unused surgical equipment seems unnecessary when we know we haven’t used them during the surgery”
- In laparoscopic surgeries, it is unlikely that anything is left in the patient
- “The doctor didn’t do the counting, so why does he have to acknowledge it?”

What are the recommendations?
It is crucial that RNs and other operating room staff recognize the importance of using hospital policy and procedures, as they are based on best practice. Inattention to these details may lead to unintentional patient harm.
- Auditing operative records to ensure that counts were completed and documented correctly
- The use of radiopaque equipment to increase visibility of objects
- Conducting random “real time” to monitor compliance with the policy
- Initial and ongoing competencies to monitor knowledge and practice of operating staff
- Have a printed copy of the policy readily available at the nurse’s station for reference
- Base the policies and procedures on the AORN Perioperative Standards and Recommended Practices
- Incorporate technology (RFID) into the counting process when further research is done on the safety and efficiency

References


DON’T health care workers CLEAN their STETHOSCOPE?

Dao Lao, Gaujah Moua, Mao Chong Lee

Objective: To determine stethoscope cleaning among health care workers in clinical settings through literature review and clinical observations.

Problems: Bacteria growth, lack of policy and procedure, insufficient cleaning and resources.

Clinical Observations:
Setting: rural hospital medical surgical units.
Population: health care workers (physicians, nurses, respiratory therapists and students).
Method: random observations over a three day period in different situations
Result: zero percent cleaned.
Conclusion: no policy and procedure in place; health care workers did not clean stethoscopes between use.

Study 1: Prevalence of MRSA on the Stethoscopes of Emergency Medical Services Providers
Setting: urban tertiary care center with 80,000 patients per year.
Population: Emergency medical service providers.
Purpose: to evaluate for prevalence of MRSA.
Method: observational cohort study of 50 stethoscopes. Diaphragms were swabbed and cultured. Questioners given to state when last cleaned stethoscopes; the responses were categorized into six categories.
Results: MRSA found on diaphragms. Increased cleaning frequency was related to decreasing bacterial growth.
(Merlin, Wong, Pryor, Ryan, Marques-Baptista, Perritt, et al., 2008)

Conclusion: Normal flora and pathogenic bacteria can be transmitted to patients through the use of stethoscopes. Increased frequency of cleaning is related to the reduction of bacteria colonization.

Implications and Recommendations:
• Easy access to alcohol based disinfectants
• Emphasize and educate stethoscope cleaning
• Establish policy and procedure
• Stethoscope cleaning = hand washing!!!

Study 2: Bacterial Contamination of Stethoscopes on the Intensive Care Unit
Setting: 12 beds mixed surgical and medical ICU.
Population: 44 healthcare workers.
Purpose: to determine the rate of cleaning stethoscopes and types of disinfectants/bacteria
Methods: questionnaires regarding frequency of stethoscope cleaning with sterile cotton balls and inoculated into MacConkey agar plates.
Results: Pathogenic bacteria present on stethoscopes. Alcohol wipes preferred.
(Whittington, Whitlow, Hewson, Thomas & Brett, 2009)

Study 3: Bacteriological Assessment of Stethoscopes used by Medical Students in Nigeria: Implications for Nosocomial Infection Control
Setting: Ebonyi State University Teaching Hospital, clinical setting.
Population: Medical students who had their stethoscopes.
Purpose: to gather information regarding demography, handwashing stethoscope usage, and handling and maintenance practices.
Method: anonymous questionnaire.
Results: of 201 stethoscopes, 161 (80.1%) had bacterial contamination.
(Uneke, Ogbonna, Oyibo & Ekuma, 2009, 2010)

References:
FACULTY TRAINING STRATEGIES

- Raised awareness of the need for incorporation of the QSEN Competencies – ie showed Lewis Blackman & Chasing Zero videos
- Buy in from faculty regarding Student Learning Outcomes representing QSEN/IOM competencies.
- Lewis Blackman video has been incorporated into the curriculum for student viewing
- Faculty discussions about existing exercises that could be incorporated into current classes
- Adopted the philosophy of a culture of safety and root cause analysis for student error
SO NOW WHAT?

- New Student Learning Outcomes based on IOM Competencies
- Semester meetings during summer to plan assignments
- One Day workshop for part time faculty
- Dedicated planning time at each faculty meeting