from the Beginning: The What and Why of Quality and Safety Competencies

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2012 QSEN National Forum
Central Questions:

- What are driving forces for changing the mindset about quality and safety science?
- What are innovations for integrating the six QSEN competencies into nursing curricula, teaching, and clinical practice?
- What are shared experiences to improve quality and safety outcomes?
Reflection: Acting Purposefully to Co-Create the Learning Environment

- What do you want from this session?
- What is the value of this session in terms of what you gave up to be here?
- What are you willing to invest to achieve your purpose?
Mental Models: Changing paradigms
What are examples of changing views, practices and policies related to safety all around us that are built on quality improvement data?
How do we adopt this mind set in health care?
Pop Quiz!
What do we know about quality and safety?
1. According to the IOM how many deaths occur each year due to medical errors?

A. 44,000 and 98,000
B. We do not know.
C. 1 million
D. 25,000 – 35,000
2. According to the IOM, what are the leading causes of unexpected deaths in health care settings?

A. Cardiac arrest
B. Stroke
C. Emboli
D. Medical errors
3. Which accounts for the largest number of patient deaths?

A. Breast cancer  
B. AIDS  
C. Motor vehicle accidents  
D. Adverse and sentinel events
4. The root cause of 65% of sentinel events is:

A. Communication
B. Lack of training
C. Provider intention
D. Lack of caring
5. What is the economic cost of medical error annually?

A. $8 billion to 29 billion
B. $1,000,000 - $20,000,000
C. $1 billion to 10 billion
D. $500,000,000 to $800,000,000
6. What is the cost in human terms?

A. Pain and suffering  
B. Moral distress and erosion of trust  
C. Staff disengagement  
D. All of the above
Evidence: IOM Quality Chasm Series

- To Err Is Human: Building a Safer Health System (2000)
- Crossing the Quality Chasm: A New Health System for the 21st Century (2001)
- Health Professions Education: A Bridge to Quality 2003
- Identifying and Preventing Medication Errors (2006)
Guiding Principle:
There are some patients whom we cannot help. There are none whom we cannot harm. A. L. Bloomfield
Changing Mindset for Quality and Safety

- Health care lags behind other high performance industries

- System approach: analyze errors to identify contributing factors to redesign the system to prevent future occurrences.

A new Mindset:
Focus on system design/prevention rather than blaming individual performance
System focus: High Reliability Organizations (HROs)

- Complex, intermittently, intensely interactive
- Perform exacting tasks under time pressure
- Few catastrophic failures over several years
- Focus: Where is the next error likely to occur?
  - See HROs at www.AHRQ.gov
Quality, Safety: Enduring Values for Doing the right thing

Will, Idea, Execution

- Nurses have the Values
- When they have the resources
- To do good work
Moral, ethical and economic factors: Quality is good business:

- Nurses with resources to do work well experience satisfaction which contributes to a positive work environment, remain engaged, and have high retention.

- Consistent with Magnet standards.

How do we create the change required?
Goal is to Focus Health Care Professional Formation to:

- Lead continual improvement of the quality, safety and value of health care:
  - Identify good care from the scientific evidence
  - Identify gaps between the actual measured performance and accepted good care
  - Participate in activities to help close any gap(s).

What are the gaps in educational preparation?
All health professionals should be educated to deliver patient-centered care as members of interdisciplinary teams, emphasizing evidence-based practice, quality improvement, safety, and informatics.

Committee on Health Professions Education
Institute of Medicine (2003)
Emerging questions:

What would be the approach for nursing?

Who would lead the change?

How should the competencies be defined to achieve the change needed?

What is the content needed in nursing curricula?
From the University of North Carolina - Chapel Hill School of Nursing

Quality and Safety Education for Nurses

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Gwen Sherwood, Co-Investigator
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Welcome

Welcome to QSEN, a comprehensive resource for quality and safety education for nurses! Faculty members worldwide are working to help new health professionals gain the knowledge, skills, and attitudes to continuously improve the health care systems in which they work. This website is a place to learn and share ideas about educational strategies that promote quality and safety competency development in nursing.

Faculty Development

Faculty resources on this website include annotated bibliographies and teaching strategies submitted by faculty like you who are attempting to help students develop the knowledge, skills and attitudes essential to the development of quality and safety competencies. Faculty from 15 nursing schools participated in the QSEN Learning Collaborative in Phase I. You can view a list of our pilot schools here.

We invite you to use this website to share with other nursing educators your ideas for improving quality and safety education for nurses. To upload a teaching strategy, please click here.

…To transform nurse identity to include quality and safety as a core part of what they do…

www.qsen.org
Phases I-IV 2005-2012

I.
- Assess the current stage of curricular integration
- Work through Expert Panel and Advisory Board
- Engage stakeholders by raising awareness
- Identify Pre-licensure competencies with KSAs

II.
- Model with Pilot School Learning Collaborative
- Define Graduate competencies with KSAs
- Sharing through National Forums

III. & IV.
- Faculty development through multiple avenues including AACN regional workshops
- Integrate into textbooks, licensure & accreditation standards and transition to practice
QSEN: Will, Idea, Execution

Build Will for changing mindset

- Assessment to describe the gap between what is and what could be
- Stimulate awareness of why we need to change
- Establish Expert Panel and Advisory Board
- Partner with early adopters to stimulate and spread ideas
QSEN: Will, Idea, Execution

Generate and Share Ideas

Define competencies with the knowledge, skills, and attitudes (KSAs) as learning objectives

Attract innovators for demonstration projects

Share teaching strategies for all educational settings
QSEN strategies: Will, Idea, Execution

Integrate into nursing education

Develop open source robust website

Train early adopters to train others

Disseminate to organizations for licensure, certification and accreditation and transition to practice programs

Work with publishers and authors to integrate quality and safety concepts

QSEN strategies: Will, Idea, Execution

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Delphi Study for placement of competencies in the curriculum

N= 18 QSEN experts

- Implement as curricular threads
- Early in curriculum: individual patient
- Later: teams and systems
- Advanced courses: complex concepts
  - Teamwork and collaboration
  - Evidence-based practice
  - Quality improvement
  - Informatics

Where do we start?

- Barton et al, Nov-Dec 2009 *Nursing Outlook*
Need to improve:

- **Knowledge** for Teamwork and collaboration, Quality improvement
- **Attitude** for using quality improvement tools, locating evidence reports for clinical practice guidelines, and evaluating the effect of practice changes using QI
- **Skills** to Consult experts before deviating from EBP protocols, Evaluate the effect of practice changes using quality improvement methods and measures and Use organizational systems for near-miss and error reporting from Hirst & Sullivan, Nov-Dec 2009 Nursing Outlook
Phase III: Resource Development

- AACN: Faculty Development Regional Workshops for train the trainer
- UNC 3 National forums

- 40 expert Facilitators
- Continue VAQS Scholars
- Website Learning Resources: Lewis Blackman Videos, Learning Modules, Teaching strategies
- Book chapters, publications, textbook integration
- More than 100 citations
- Textbook integration, publications
To Learn more: QSEN Publications

- Special topic issues:
  - Phase I *Nursing Outlook* May-June 2007
  - Quality in Nursing *Urologic Nursing* Dec 2008
  - Projects *Journal of Nursing Education* Dec. 2009

- Book chapters, additions to textbooks, more than 100 citations

- Text: *Quality and Safety Education: A Competency Based Approach*, Sherwood & Barnsteiner
Describing the new mindset for Nurses’ work

A Quality Culture: “A new way of thinking like a nurse”

- Engages in their work with the patient as the focus
- Encourages inquiry and reflection to make sense of experience
- Applies evidence based standards and interventions
- Investigates outcomes and critical incidents from a system perspective
- Continually seeks to improve care
**Patient Centered Care:**

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<tr>
<th>Define:</th>
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<td>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.</td>
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<th>Expectation:</th>
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<tr>
<td>Applies knowledge of patient values and preferences in caring for patient and with others on the care team</td>
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<td>Includes patient and family as allies in safety</td>
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Patient-centered Care

- Negotiate with patients to incorporate their preferences and values into individualized plans of care to help assure good outcomes
- Coordinate complex care with multiple disciplines
- Includes patient and family as allies in safety
Teamwork and collaboration:

Define:
Function effectively in nursing and inter-professional teams, fostering open communication, mutual respect, and shared decision-making to achieve quality patient care.

Expectation:
- Use personal strengths to foster effective team functioning (EQ)
- Integrate quality and safety science in communicating across diverse team members
- Shift leadership as needed
- Include patient and family as members of the health care team
Standardized communications among teams:

- Use TeamSTEPPS for learning team communication: SBAR, CUS, Check-backs, Check-lists for handoffs (www.AHRQ.gov)

- Interprofessional rounds to discuss patients’ daily care goals,

- Practice Nurse – physician communications to improve informed physician decision-making and team communication (simulation)
Evidence-based practice:

Define:
Integrate best current evidence with clinical expertise and patient/family preferences and values for delivery of optimal health care

Expectation:
- Applies technology to search evidence for best care approaches and clarify decisions.
Base care standards and protocols on scientific evidence

- Apply levels of evidence to care plan
- Assess actual patient care against the standard of care and known best practice
- Formulate a clinical question from a case study for students to write an evidenced based standard.
Example: wound care

- Trace the history of how we treat wounds
- What are examples you have used in your career for wound care?
- Why did each change occur?
- What are the ways to apply teamwork and collaboration to wound care?
- What are questions about patient centered care?
Quality improvement:

Define
Use data to monitor the outcomes of care processes and use improvement methods to design and test changes to continuously improve the quality and safety of health care systems

Expectation:
- Quality improvement integrated into nursing role and identity
- Uses quality tools, evidence, patient preferences, and benchmark data to assess current practice and design continuous quality improvements
How would you apply each of these to QI for wound care?

- Rapid Cycle Change
- Benchmarks
- Human factors
- Root cause analysis
- Trending
- Variance reports
- PDSA
Safety:

Define:

Minimize risk of harm to patients and providers through both system effectiveness and individual performance

Expectation:

Awareness of actions that may put patients at risk for possibility of error

Follow just culture

Implements, works with system alerts for safety

Seeks solutions to workarounds and evaluates short cuts

Works with patient and family and team members as safety allies
Putting the Science in Safety

- More than “5 rights” of medication administration, assessing risks for falls, environmental monitoring.

- “Just culture” advocates open reporting and learning from adverse events and near misses

- Root-cause analyses of safety events and near misses conducted and looped back to improve the system.

- Model behaviors that welcome ‘clarifying’ questions when any team member sees the possibility of an error.
**Never events: preventable errors (ex. wrong site surgery)**

Red Rules apply standards without exception in a particular process (ex. sponge count)

Are we teaching Error Reduction strategies?

- Education and training
- Rules and policies
- Checklists and double-check systems
- Standardization and protocols
- Automation and computerization
- Forcing functions and constraints
Informatics:

Define:
Use information and technology to communicate, manage knowledge, mitigate error, and support decision making

Expectation:
Use electronic record systems
Search for and evaluate information sources
Navigate computer decision supports
Evaluate technologies for their potential to cause or mitigate error.
Help design and evaluate relevant products
9 universal patient safety strategies:
http://www.jointcommissioninternational.org/24946/

1. Confusing drug names that sound/look alike
2. Confirming patient identification
3. Performing correct procedure, correct site
4. Control of concentrated drug solutions
5. Assuring medication accuracy during transitions
Checklist of safety strategies to avoid mistakes

6. Catheter and tubing misconnections
7. Single use injection devices
8. Improved hand hygiene
9. Communication during patient hand-offs

How do we include these precautions in student learning?
Co-Creating the Learning Environment

- Learner centered
- Learner input
- Accountability
- Reflective
- Engaging, inquiring, self-managing
From the Pilot Learning Collaborative: Integration using a variety of pedagogies will yield more effective change.

Thread through nursing and interprofessional courses: class, technology, simulation/skills lab, clinical learning

- New Questions
- Narrative pedagogies
- Unfolding case studies
- Web Modules
- PBL
- Readings
- Papers
- Clinical Partners
- Reflective Practice
Questions about education to change practice:

- What are embedded assumptions in nursing education?
- How do we engage students?
- How can we rethink nursing fundamentals?
<table>
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<th>The realities of practice: Human factors in quality and safety</th>
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<tr>
<td><strong>Workload fluctuations</strong></td>
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<td><strong>Interruptions</strong></td>
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<td><strong>Failure to follow up</strong></td>
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<td><strong>Ineffective communication</strong></td>
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<td><strong>Not following protocol</strong></td>
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<td><strong>Excessive professional courtesy</strong></td>
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<td><strong>Halo effect</strong></td>
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<td><strong>Passenger syndrome</strong></td>
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<td><strong>Hidden agenda</strong></td>
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<td><strong>Complacency</strong></td>
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<td><strong>High-risk phase</strong></td>
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<td><strong>Task (target) fixation</strong></td>
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Pedagogies of Engagement: the capacity to get students actively involved with learning in new ways

- **Critical reflection**: using reflection to critique one’s work to make informed decisions for future choices.

- **Judgment and design**: work environments have uncertainty and ambiguity. How do learners exercise judgment to meet the needs of particular patients in particular situations?

- **Commitment and identity**: seeing the relationship among decisions in practice from a values perspective. Seeing who are as nurses, leads to commitment and new engagements.
  - Shulman 2000
Shulman’s Table of Learning (2000)
Pedagogy of Engagement
Clinical Judgment Model  Tanner, 2006

Noticing

Interpreting

Reflecting

Responding

Clinical Judgment

Thinking like a nurse: Making sense of practice
Reflection helps fit the puzzle together to make sense of experience and knowledge.

Helps improve performance and move to professional maturity.
Building EQ: Reflective Writing

- Learning to write or **writing to learn**?
  - purposeful writing to order thoughts and connect ideas
  - creates a record; dialogue

- Each Day: Write for one minute on the most important lessons you learned today. How can it help you?

- Develop rubrics to assess
Unfolding Case Studies

- Use theory bursts for content
- Outline case and learning objectives
- Develop scenario, characters, setting, clinical situation, symptoms, and details included or omitted such as lab data, physician orders, medications, diet, treatments
- Establish directed questions for students as well as give time for their questions
- What assessments can students contribute?
- How will you evaluate?
What questions do you have about integrating the competencies?

- What are best practices to share with other schools and practice settings?
- What challenges have you overcome in your setting?
- How are you assessing outcomes?
Daily Reflections to integrate learning

- Write for one minute to summarize your participation in the session today.
  - Consider how you felt during discussions.
  - What lessons did you learn?
  - What behavior will you change?
  - What are gaps in your learning to focus on?
The new face of nursing: Doing the right thing all the time
References

- Annotated bibliography on [www.qsen.org](http://www.qsen.org)


- Sherwood & Horton-Deutsch, *Reflective Practice: Engaging Learners and Improving Outcomes*, Due June 2012 Sigma Theta Tau Press.