



Graduate Education and the QSEN Competencies: The Role of Preceptors

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Objectives

- Participants will identify resources and strategies to support and emphasize development of the QSEN competencies for graduate education for advanced practice registered nurses in the preceptor role.

Have a Plan

1. Introduce Students to the Competencies.
2. Create graded assignments that help students recognize the knowledge, skills, and attitudes required to meet QSEN competencies for graduate education.
 - Column on Log of hours
 - Quality Improvement project
 - EBP project to reduce variation
 - Identification of Patient safety threats in setting
3. Provide guidance for preceptors to help them emphasize the competencies in clinical practice.
 - Tools and supports that reinforce the QSEN competencies

Patient Centered Care

- **Patient is in control and a full partner; care is based on respect for patient's preferences, values, and needs.**
 - Consider patient's cultural preferences
 - White board initiatives for patient goals
 - IHI Home Page Patient Centered Care 101 1.5 contact hrs
 - The Picker Institute-Advancing the Principles of Patient-Centered Care <http://pickerinstitute.org>
 - Institute for Patient- and Family-Centered Care <http://www.ipfcc.org>
 - <https://www4.georgetown.edu/uis/keybridge/keyform/form.cfm?formID=277>

Patient Centered Care

- Keep focused on patient goals and solving problems at the point of care
- Promote relationship building with patients

First Touch – Home

- **Involve patient in all we do**
 - Situational Awareness
 - Rapid response teams to avoid codes on Med-Surg units
 - Personal accountability in all we do
 - Reducing admission rates
 - Helping nurses obtain new skill sets
 - <http://www.ihl.org/offerings/Initiatives/PastStrategicInitiatives/TCAB/Pages/Materials.aspx>

Teamwork and Collaboration

- **Achieve quality patient outcomes by effectively communicating with nurses and inter-professional teams having mutual respect and shared decision making.**
 - Synergistic effects of effective interdisciplinary collaboration
 - System based solutions for Safe hand-offs
 - Acknowledging other team members contributions
 - Ability to raise concerns; Assertion
 - CUS (concerned, uncomfortable, safety)
 - 2 challenge rule
 - Critical Language *“I need some clarity.”*
 - Rapid Response Teams

Teamwork and Collaboration

Effective Communication

- SBAR
 - Situation
 - Background
 - Assessment
 - Recommendation

SBAR worksheet.pdf - Adobe Reader

File Edit View Document Tools Window Help

SBAR report to physician about a critical situation

S	<p><u>Situation</u> I am calling about <u>-patient name and location-</u>. The patient's code status is <u>-code status-</u>. The problem I am calling about is _____. I am afraid the patient is going to arrest.</p> <p>I have just assessed the patient personally:</p> <p>Vital signs are: Blood pressure _____ / _____, Pulse _____, Respiration _____ and temperature _____</p> <p>I am concerned about the:</p> <p>Blood pressure because it is _____ over 200 or _____ less than 100 or 30 mmHg below usual Pulse because it is _____ over 140 or _____ less than 50 Respiration because it is _____ less than 5 or _____ over 40. Temperature because it is _____ less than 96 or _____ over 104.</p>
B	<p><u>Background</u> The patient's mental status is: Alert and oriented to person place and time. Confused and _____ cooperative or non-cooperative Agitated or combative Lethargic but conversant and able to swallow Stuporous and not talking clearly and possibly not able to swallow Comatose. Eyes closed. Not responding to stimulation.</p> <p>The skin is:</p> <p>Warm and dry Pale Mottled Diaphoretic Extremities are cold Extremities are warm</p> <p>The patient _____ is not or _____ is on oxygen. The patient has been on _____ (l/min) or (%) oxygen for _____ minutes (hours) The oximeter is reading _____ % The oximeter does not detect a good pulse and is giving erratic readings.</p>
A	<p><u>Assessment</u> This is what I think the problem is: <u>-say what you think is the problem-</u> The problem seems to be cardiac Infection neurologic respiratory _____ I am not sure what the problem is but the patient is deteriorating. The patient seems to be unstable and may get worse, we need to do something.</p>
R	<p><u>Recommendation</u> I suggest or request that you <u>-say what you would like to see done-</u> transfer the patient to critical care come to see the patient at this time. Talk to the patient or family about code status. Ask the on-call family practice resident to see the patient now. Ask for a consultant to see the patient now.</p> <p>Are any tests needed: Do you need any tests like CXR, ABG, EKG, CBC, or BMP? Others?</p> <p>If a change in treatment is ordered then ask: How often do you want vital signs? How long do you expect this problem will last? If the patient does not get better when would you want us to call again?</p>

Teamwork and Collaboration

- Leadership during high stress team efforts
 - Pre-briefing
 - Usually conducted by team leader, reviews plan with team before beginning.
 - Debriefing
 - Feedback whether positive or negative should always be an unbiased reflection of events and open the door to discussion of evidence-based practice
- Conflict Management Strategies
- *TeamSTEPPS Tools and Videos*
 - *TeamSTEPPS*
<http://www.ahrq.gov/teamsteppstools/instructor/videos.htm>

Evidence Based Practice

- **Integrate best current evidence, clinical expertise, and patient preferences and values to deliver optimal health care.**
- Reduce Variability through evidence
 - Integration of Standards
 - “It’s less of a thing to do...it’s more of a way to be”
 - Handwashing
 - Proper hygiene for in and out of room
 - Pressure ulcer prevention
 - Ventilator associated pneumonia prevention
 - Influenza/pneumococcal disease prevention

Evidence Based Practice

- Translate new knowledge into practice
 - Provide guidance in weighing evidence
- Share the evidence that links studies to optimum clinical outcomes and business results
 - <http://www.guidelines.gov/> National Guideline Clearinghouse | Home
 - *The Cochrane Collaboration*
- Identify those at risk for infection
 - Bundles and protocols
 - [Joint Commission Bundles to prevent infection](http://www.jcrinc.com/HAITKo9/Extras/)
<http://www.jcrinc.com/HAITKo9/Extras/>

Quality Improvement (QI)

- **Monitor outcomes of care processes and use improvement methods to design and test changes to improve the health care system.**
 - Culture of Safety
 - Report errors/adverse events/near misses
 - Safe to ask for help
 - System wide transformation
 - IHI Open School Quality Improvement 101-106 9 contact hrs
- Look at waste and variation and eliminate it
 - Identify where to make changes in the system
 - Tools and Strategies for Quality Improvement and Patient Safety
- <http://www.ncbi.nlm.nih.gov/books/NBK2682>

Quality Improvement (QI)

- Mistake proofing
 - Mistake-proofing the Design of Health Care Processes: Chapter 2
<http://www.ahrq.gov/qual/mistakeproof/mistake2.htm>
- NDNQI Pressure Ulcer Training
 - National Database of Nursing Quality Indicators
<https://www.nursingquality.org/Default.aspx>

Quality Improvement:

Providing Constructive Feedback

- Address faulty interpretations
- Provide options for improvement
- Most effective when focused on
 - Task
 - Process
 - Self-regulation; error detection skills

Adds to knowledge base

- Least effective when focused on
 - Person him/herself

Doesn't add to knowledge base

- Feedback whether positive or negative should always be an unbiased reflection of events

Strategies to provide Feedback



- Model appropriate techniques
- Focus on quality and safety aspects
- Emphasize as opportunity for learning/improvement
- Feedback with strategies for improvement
- Debriefings after complicated patient care situations
- Clear communication
 - sender; receiver; acknowledgement
- Approach from a patient-centered viewpoint
- Answer questions without shaming
- Role playing
- Use of Reflection

Safety

- **Minimize risk of harm to patients and providers through both system effectiveness and individual performance.**
- **IHI Open School Patient Safety 100-106 8.25 contact hrs**
 - Two patient identifiers
 - Patient armbands where standardized
 - Correct surgery/Correct site
 - Medication reconciliation
 - Standardization of medications
 - Identify Work-arounds
 - Time outs
 - Huddles
 - Non-verbal communication requires confirmation

Safety

- Speak the language of quality and Safety
 - AHRQ Glossary <http://www.psnet.ahrq.gov/glossary.aspx>
- Resources for patient safety information
 - [National Patient Safety | Joint Commission](http://www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals)
<http://www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals>
 - [AHRQ Patient Safety Network](http://www.psnet.ahrq.gov/)
<http://www.psnet.ahrq.gov/>
 - [Anesthesia Patient Safety Foundation](http://www.apsf.org/)
<http://www.apsf.org/>

Culture of Safety VS Culture of Blame: Fairness Algorithm

1. Did the individuals intend to cause harm?
2. Did they come to work drunk or impaired?
3. Did they do something they knew was unsafe?
4. Could two or three peers have made the same mistake in similar circumstances?
5. Do these individuals have a history of involvement in similar events?

▶ Applying the Fairness Algorithm

- <http://www.youtube.com/watch?v=8le7vYPUwaM>

Informatics

- **Use information and technology to communicate, manage knowledge, mitigate error and support decision making.**
- Navigate resources
 - Medical Record
 - Utilize data bases effectively
- Use technology to seek information
 - [Creating Run Charts - YouTube](#)
- Use technology to report concerns
 - [Institute For Safe Medication Practices](#)
<http://www.ismp.org/>
- Model life long learning



Resources

QSEN Teaching Strategies

- <http://www.qsen.org/>



- Questions?

Thank you!

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