Incorporating Quality and Safety Education for Nurses (QSEN) Competencies into Clinical Education

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Learning Objectives

• Describe the Quality and Safety Education for Nurses (QSEN) competencies

• Describe strategies for incorporating QSEN competencies into clinical education
Is safety a problem in Jordan?

Medication errors
nurses failed to report medication errors because they were afraid of the reactions that they will receive from their nurse managers (N=163, 78.%) and their coworkers (N=148, 72%).

(Mrayyan, 2012, Table 5)

Adverse events in Jordan

medication errors (reported by 56% of participants)
wrong diagnosis (21%)
infections (21%)
bedsores (16%)
falls (8%)
transfusion errors, identification errors and death

(Hayajneh, AbuAlRub, & Almakhzoomy, 2010)
Background

US Institute of Medicine defined six aims for health care

- Safe
- Effective
- Patient centered
- Timely
- Efficient
- Equitable

What is QSEN?

A project that addresses the challenge of preparing future nurses with the knowledge, skills, and attitudes necessary to continuously improve the quality and safety of the healthcare systems within which they work.
QSEN Competencies

• Patient centered care
• Teamwork and collaboration
• Evidenced based practice
• Quality improvement
• Safety
• Informatics
The Problem

How do we help students develop the

• knowledge
• skills
• attitudes

of safe practice?
Focus on Systems and Individual Quality and Safety

Quality and safety needs to be emphasized in every course
- clinical
- classroom
- skills lab
Systems Problems

- Systems can be made safer by design
- Analysis of events can guide design
- A root cause analysis (RCA) is a process for identifying the multiple contributing factors that underlie adverse events and near misses
- Focus of a RCA is on systems and processes
Individual Performance

Important considerations

• Knowledge and skills
• Motivation and attitude
• Physical and mental health
Knowledge

Build the vocabulary of safety
  • Incorporated into all classes
  • Use the terminology consistently

  Fair and just culture
  Sentinel event
  Near miss
  Never event
  Root cause analysis
  Performance gap
Skills

Clinical is the ideal setting for practicing safety skills

• Have students conduct a safety inspection
• Have students conduct a root cause analysis
• Write an incident report for a medication error
• Identify work-arounds
Attitudes

• Seeing patient’s situation from the patient’s perspective
• Valuing their own contribution to the team’s efforts
• Appreciating the importance of quality improvement
Clinical Evaluation Tools

Must align with the KSA competencies that are expected of the students
Strategies to Increase QSEN Competencies

To improve communication (essential for safety and teamwork)
  • ISBAR

To improve safety
  • Root Cause Analysis

To improve teamwork
  • Interviewing team members

Have students describe how they met the competencies each clinical day (provide definitions).
Improving Communication

Using ISBAR

- Introduction
- Situation
- Background
- Assessment
- Recommendation

QSEN competencies: teamwork and collaboration, safety, patient centered care
ISBAR

Introduction
• State your name, unit, patient name and identifiers (age, physician)

Situation
• what is going on with the patient?

Background
• what are the clinical facts surrounding the problem?

Assessment
• What do I think the problem is?

Recommendation
• What should be done to correct the problem?
| **INTRODUCTION** | State your name, designation, ward/unit  
  State the patient's name, age, sex and/or Admitting Doctor |
| **SITUATION** | "I am calling about" - state the reason for the call or referral  
  Explain what happened to trigger this conversation  
  High stakes – medical emergency – time dependent  
  Articulate your concern |
| **BACKGROUND** | State age sex and reason for admission  
  History of current problem  
  State any **relevant** medical, surgical or social background  
  A brief synopsis of treatment to date |
| **ASSESSMENT** | State the patient's current vital signs and observations, outline what is recorded on the chart  
  Explain what you think the problem is or what possibilities you are considering  
  State what you have done for the patient so far |
| **RECOMMENDATION / RESPONSE** | **SO WHAT? Or WHERE TO FROM HERE**  
  This can include your recommendation, or you can be refer to seeking the other persons recommendation.  
  State what you are looking for from the other person  
  "I need you to review the patient" (PROVIDE A TIME FRAME) or "I need a management plan for this patient"  
  READ BACK OR REPEAT WHAT WAS SAID TO CONFIRM WHAT YOU HEARD |
Incorporating ISBAR into the Clinical Experience

Low fidelity simulation
- transfer handoff
- patient in distress (call to physician)
- change of shift report

Essential to critique and debrief student performance
Root Cause Analysis (RCA)

An error analysis tool whose central tenant is to identify the underlying problems that increase the likelihood of errors while avoiding the trap of focusing on mistakes of individuals.
Root Cause Analysis (RCA)

1. Identify what happened
2. Review what should have happened
3. Determine causes
4. Develop causal statements
5. Generate list of recommended changes
6. Share findings

Factors can include: task, staff, patient characteristics and work environment.
Incorporating RCA into the Clinical Experience

Scenario: The patient is given the wrong dose of insulin

Focus on systems factors that caused the error. Individual’s knowledge can be considered a systems factor.
For more information

QSEN Institute [http://qsen.org/](http://qsen.org/)

A central repository of information on

- the core QSEN competencies
- KSAs
- teaching strategies
- faculty development resources
Additional Sources

Special issues devoted to quality and safety:

• *Nursing Outlook* (2009). 57(6).
• *Journal of Nursing Education* (2009). 48(12).


References


