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

Susan A. LaRocco PhD RN FNAP

Curry College

Milton, Massachusetts USA

slarocco0603@curry.edu

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

Institute of Medicine. (2001). *Crossing the Quality Chasm.* National Academy Press *(www.nap.edu)*

What is QSEN?

A project that addresses the challenge of preparing future nurses with the

knowledge
skills
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

- **I**ntroduction
- **S**ituation
- **B**ackground
- **A**ssessment
- **R**ecommendation

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/

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

Cronenwett, L., Sherwood, G., Barnsteiner, J., Disch, J., Johnson, J., Mitchell, P., Sullivan, D.T. & Warren, J. (2007) Quality and safety education for nurses. *Nursing Outlook*, *55*(3),122-31.

Hayajneh, Y., AbuAlRub, R., & Almakhzoomy, I. (2010). Adverse events in Jordanian hospitals: Types and causes. *International Journal of Nursing Practice*, *16*(4), 374–380.

Kelly, P., Vottero, B., & Christie-McAuliffe, C. A. (2014). *Introduction to Quality and Safety Education for Nurses: Core Competencies.* New York: Springer.

References

Kesten, K. (2011) Role-play using SBAR technique to improve observed communication skills in senior nursing students. *Journal of Nursing Education, 50(2*), 79-87.

Lambton, J. & Mahlmeister, L. (2010). Conducting root cause analysis with nursing students: Best practice in nursing education. *Journal of Nursing Education, 49*(8), 444-8.

Mrayyan, M. (2012). Reported incidence, causes, and reporting of medication errors in teaching hospitals in Jordan: A comparative study. *Contemporary Nurse, 41*(2), 216–232.

Penn, C. E. (2014). Integrating just culture into nursing student error policy. *Journal of Nursing Education, 53*(9), S107-S109.