Editorial
Are Nurses Prepared to Work in Systems Focused on Quality and Safety?
Gwen Sherwood

Author Background:
Professor Gwen Sherwood is the Associate Dean for Academic Affairs at an historic university in the USA, the University of North Carolina at Chapel Hill. She is well published, an active researcher, has many areas of expertise, including quality and safety in health care and nursing. She is currently a co-investigator on a large project: the Quality and Safety Education for Nurses Project. Professor Sherwood is a global leader in nursing, being the Vice-President, Sigma Theta Tau International Honor Society for Nursing; and among many of her roles, she is a member of the Global Nursing Advisory Group of UNC School of Nursing, working internationally. She is therefore an expert to write in our Journal on this topic.
Quality and safety are global issues with prestigious agencies around the world continuing to report poor patient outcomes. Preventable adverse and sentinel events occur with startling frequency in health systems in nearly every country. The World Health Organization and the International Council of Nursing have each issued position statements, recommendations, and guidelines for improving quality and safety. To improve health care outcomes requires education in the new quality and safety science for health care providers, as well as changes in academic curricula to assure a work force prepared to lead the improvements demanded by regulatory agencies.

These reports have stimulated changes in many health care systems through a transition to a new accountability for quality and safety for which nurses and other disciplines may not be prepared. In health care, adverse and sentinel events and near misses usually occur one at a time. Lack of aggregate reporting has enabled process and system issues to remain undetected, sometimes repeating the same errors. When inadequate resources or services are available, workers may develop “work arounds” to overcome staff shortages or hindrances in completing a task. That is, they find shortcuts to standard methods to complete their work in ways that may compromise safety and quality, or may be an indication a process needs to be changed. Other high performance industries such as aviation, nuclear power, and railway have applied new quality and safety science to dramatically improve safety outcomes. Formal reporting requirements aggregate data on errors, near misses and poor outcomes from across the industry so that repeated system issues can be detected, analyzed, and changed to establish new evidence-based procedures that may build in a checks and balance to prevent occurrences. One example of a system change is tubing misconnections, a preventable but frequently occurring error. Portals can be mismatched when a patient has multiple invasive tubes, such as intravenous tubes, drainage pumps, a nasogastric tube, or a urinary catheter. Solutions may involve changes in equipment purchasing that prevent mismatching or color coding tubes and ports to avoid misconnections.

Health care errors have historically been handled by identifying the individual who was believed to have caused the error to establish blame. Implementing new safety science from other industries has led to efforts to change the blame environment to a “just culture” organizational framework. In such an environment, mistakes are reported but are studied through root cause analysis or other systematic means to trace each action step to determine where additional information or other decisions could have been made. Staff trained in risk management gather together individuals involved in any stage of the event to identify the pathway leading to the error, and to define action plans to prevent future occurrences. Patients and families are kept informed to maintain transparency of what happened. Accountability still rests with the individual to be attentive to potential error and to report near misses and adverse events. However, the emphasis shifts to safe reporting as a learning tool and to help families get answers to their questions about the event.

Health care institutions rely on quality reporting to identify gaps between industry benchmarks among peer institutions and their own quality data. As the provider who spends more time with patients, nurses increasingly lead data collection on nurse-sensitive indicators as well as other quality markers and help design quality improvement initiatives to close gaps. Analysis of current educational curricula illustrates the challenges experienced by nurses and new graduates who lack training in quality improvement tools about how they can use quality data and current literature to design and implement evidence-based standards to improve care. Nurses alone cannot make the sweeping changes needed. They require knowledge, skills and attitudes for collaborating across disciplines. Inter-professional teamwork is identified as the key element in 70% of medical errors in the United States, yet few schools preparing health professionals offer learning experiences that bring multiple health professions students together to be prepared for working together in complex practice environments.
The Quality and Safety Education for Nurses (QSEN) project in the United States has become a strategic voice in defining quality and safety competencies for both pre-licensure and graduate education and has led a renaissance in transforming nursing curricula and educational standards. Results of a survey of schools of nursing combined with faculty focus group data helped define the gap between changes in health care systems and nurses’ educational preparation to be able to initiate the educational changes required. The goal is to integrate quality and safety competencies into the nursing role identity. This enables nurses to practice from the framework of asking the questions about the care they deliver, leading to improving quality outcomes and patient safety from a system perspective. The QSEN project team based their work on the six competencies identified by the Institute of Medicine as key to quality reform: patient-centered care, teamwork and collaboration, evidence-based practice, quality improvement, safety; and informatics. A robust web site is available worldwide at www.qsen.org with definitions of the competencies including objectives for the knowledge, skills, and attitudes to integrate into curricula, annotated bibliographies for each competency, and peer-reviewed teaching strategies.

Twenty-first century care should be patient-centered care based on evidence-based standards, delivered collaboratively by interprofessional teams, within systems focused on continuous quality improvement and safety science, enhanced by informatics. These six competencies at first appear to be familiar terms but a closer examination of the objectives identifying the knowledge, skills, and attitudes add new quality and safety science from other high performance industries described above. Patient-centered care has been a foundation on which nursing care is based, yet has been redefined to include the patient and their family as valuable team members and safety allies. When patients and families are included in the team, their eyes and ears can help identify and prevent errors. Nurses questioned by patients and families whether they are administering the correct medication should adhere to a warning sign of potential error and stop to investigate correct administration and also help patients with new information if orders have changed. Complex care requires coordination across disciplines such as physicians, pharmacists, and others involved in a patient’s care to communicate through briefings (planning), huddles (problem solving) and debriefings (process improvement). Teamwork and collaboration is built from transformational leadership and interactional skills developed through emotional intelligence. Competence in informatics enables nurses to search literature and other sources to determine best practices that establish evidence-based standards to guide practice, implement quality improvement strategies, manage and design electronic health records, and utilize decision support resources.

To achieve the goals for quality and safety educators themselves need to be prepared in these six quality and safety competencies so they are able to lead integration across hospital education programs, continuing education offerings, and academic curricula. Innovative partnerships between practice settings and schools of nursing can design human patient simulation exercises and redesign clinical learning opportunities that facilitate mastery of the competences. Collaboration across global regions for research and evaluation studies can help determine applicability in varied settings to assess the universality of the six competencies defined by the IOM and QSEN project. What are common themes in hospital redesign and regulatory standards across countries? What are cultural considerations that impact patient centered care, teamwork and collaboration, and evidence based standards? What are pedagogies that create lasting changes in behavior and attitudes related to quality and safety? Working to improve quality and safety outcomes not only addresses our moral commitment to do no harm, but also contributes to a healthy work environment that increases worker satisfaction and retention. Through education, nurses can lead integration of quality and safety competencies and experience the joy from helping patients improve health care outcomes.
References