

QUALITY IMPROVEMENT

ANNOTATED BIBLIOGRAPHY

NEW CITATIONS – JULY 2007

Bargagliotti, L. A., & Lancaster, J. (2007). Quality and safety education in nursing: More than new wine in old skins. *Nursing outlook*, 55(3), 156-158.

The Quality and Safety Education for Nurses (QSEN) project, funded by the Robert Wood Johnson Foundation, has identified 6 core competencies that all pre-licensure nursing students need to master in order to provide high quality, safe nursing care. The core competencies are: patient-centered care; teamwork and collaboration; evidence-based practice; informatics; quality improvement; and safety. Implementation of these competencies throughout nursing education will require shedding the nursing and faculty belief systems and mental models of the past to adopt new ones. (Source: QSEN Team)

Batalden, P. B., & Davidoff, F. (2007). What is "quality improvement" and how can it transform healthcare? *Quality & safety in health care*, 16(1), 2-3.

This editorial proposes a definition of "quality improvement" as the combined and unceasing efforts of healthcare professionals, patients and their families, researchers, payers, planners and educators to make the changes that will lead to better patient outcomes (health), better system performance (care) and better professional development (learning).(Source: QSEN Team)

Cronenwett, L., Sherwood, G., Barnsteiner, J., Disch, J., Johnson, J., Mitchell, P., et al. (2007). Quality and safety education for nurses. *Nursing outlook*, 55(3), 122-131.

Quality and Safety Education for Nurses (QSEN) addresses the challenge

of preparing nurses with the competencies necessary to continuously improve the quality and safety of the health care systems in which they work. The QSEN faculty members adapted the Institute of Medicine(1) competencies for nursing (patient-centered care, teamwork and collaboration, evidence-based practice, quality improvement, safety, and informatics), proposing definitions that could describe essential features of what it means to be a competent and respected nurse. Using the competency definitions, the authors propose statements of the knowledge, skills, and attitudes (KSAs) for each competency that should be developed during pre-licensure nursing education. Quality and Safety Education for Nurses (QSEN) faculty and advisory board members invite the profession to comment on the competencies and their definitions and on whether the KSAs for pre-licensure education are appropriate goals for students preparing for basic practice as a registered nurse.

(Source:PubMed)

Day, L., & Smith, E. L. (2007). Integrating quality and safety content into clinical teaching in the acute care setting. *Nursing outlook*, 55(3), 138-143.

Teaching the highest quality and safest practice has long been a goal of faculty members in pre-licensure nursing education programs. This article will describe innovative approaches to integrating quality and safety content into existing clinical practica. The core competencies identified by the Quality and Safety Education for Nurses project-patient-centered care, teamwork and collaboration, evidence-based practice, quality improvement, safety, and informatics-serve as the framework for the teaching/learning exercises. The strategies described require a shift in attention rather than changes in course content and can be included in any clinical rotation in an acute care setting. (Source:PubMed)

Finkelman, A. W., & Kenner, C. (2007). *Teaching IOM: Implications of the institute of medicine reports for nursing education*. Silver Spring, MD: American Nurses Association.

Teaching IOM focuses on the core competencies derived from the IOM reports on quality and health care and how to use these reports in the classroom. The companion CD-ROM provides additional material for incorporating content into curricula and teaching-learning experiences. It includes PowerPoint presentations with notes on the book's five major topics; healthcare safety, healthcare quality, public health safety and quality, healthcare diversity, and linkage between research and evidence-based practice. The content is appropriate for graduate or undergraduate students. (Source: QSEN Team)

Griner, P. F. (2007). Leadership strategies of medical school deans to promote quality and safety. *Joint Commission journal on quality and patient safety*, 33(2), 63-72.

BACKGROUND: In April 2003, an informal collaborative of medical schools was convened by the Institute for Healthcare Improvement to achieve learning objectives for medical students for the improvement of care. The deans of the 10 founding schools were interviewed in 2004 regarding their strategies to achieve this goal. FINDINGS: The deans felt that their work in recruiting leaders in the field of quality, developing organizational structures to facilitate quality initiatives, empowering faculty, and promoting educational reforms were essential elements for achieving learning objectives. PROGRESS IN MEETING THE COLLABORATIVE'S GOALS: The collaborative's work is organized around themes considered essential to the goals of the collaborative such as interprofessional learning, exemplary clinical settings, student-initiated learning, and evaluation. The collaborative has grown from 10 medical schools to 48 health professions schools in three years. Pilot exemplary clinical settings for education and patient care at seven sites, along with strategies to ensure interprofessional learning at 16 of the 20 sites, represent important intermediate outcomes of the deans' initial leadership initiatives and the collaborative's faculty vision. Of the 10 founding schools, 7 continue to serve as role models for newer members.

DISCUSSION: The approaches suggest building blocks for achieving goals for improving care in academic institutions and may help other health professions schools and the clinical settings where learning takes place. (Source: PubMed)

Hallmarks of quality and patient safety: Recommended baccalaureate competencies and curricular guidelines to ensure high-quality and safe patient care.(2006). *Journal of professional nursing : official journal of the American Association of Colleges of Nursing*, 22(6), 329-330. In response to the call to better prepare today's nurses for professional practice, the American Association of Colleges of Nursing (AACN) convened a task force on essential patient safety competencies and charged this group with identifying the essential baccalaureate core competencies that should be achieved by professional nurses to ensure high-quality and safe patient care. This article presents the competencies that are the result of the work of the task force. (Source: QSEN Team)

Iedema, R. A. M., Jorm, C., Braithwaite, J., Travaglia, J., & Lum, M. (2006). A root cause analysis of clinical error: Confronting the disjunction between formal rules and situated clinical activity. *Social science & medicine*, 63(5), 1201-1212.

This paper presents evidence from a root cause analysis (RCA) team meeting that was recently conducted in a Sydney Metropolitan Teaching Hospital to investigate an iatrogenic morphine overdose. Analysis of the meeting transcript reveals on three levels that clinical members of the team struggle with framing the uncertain and contradictory details of situated clinical activity and translating these first into 'root causes', and then into recommendations for practice change. This analysis puts two challenges into special relief. First, RCA team members find themselves in the unusual position of having to derive organizational-managerial generalizations from the specifics of in situ activity. Second, they are constrained by the expectation inscribed into RCA that their recommendations result in 'systems improvements' assumed to flow

forth from an extension of formal rules and spread of procedures. We argue that this perspective misrecognizes the importance of RCA as a means to engender solutions that leave the procedural detail of clinical processes unspecified, and produce cross-hospital discussions about the organizational dimensions of care. (Source:PubMed)

Johnson, K., & Maultsby, C. C. (2007). A plan for achieving significant improvement in patient safety. *Journal of nursing care quality, 22*(2), 164-171.

Improvement in systems that ensure safety in the provision of care is a high priority to hospital administrators, clinicians, and patients. Research to determine the approaches and methods that will result in the most significant patient safety improvements is underway but more is needed. This article describes the process for improving patient safety adopted at one hospital. Results of these efforts demonstrate significant improvement in staff understanding of patient safety measures. Staff survey results are supported by improvement in clinical indicators. Recommendations for future action and implications for other hospitals are discussed. (Source:PubMed)

Ladden, M. D., Bednash, G., Stevens, D. P., & Moore, G. T. (2006).

Educating interprofessional learners for quality, safety and systems improvement. *Journal of interprofessional care, 20*, 497-505.

Most health professionals in training, as well as those in practice, lack the knowledge and skills they need to play an effective role in systems improvement. Until very recently, these competencies were not included in formal (or informal) educational curricula. Interprofessional collaboration - another core competency needed for successful systems improvement - is also inadequately taught and learned. Achieving Competence Today (ACT) was designed as a new model for interprofessional education for quality, safety and health systems improvement. The core of ACT is a four-module active learning course during which learners from different disciplines work together to develop

a Quality Improvement Project to address a quality or safety problem in their own practice system. In this paper we describe the ACT program and curriculum model, discuss our strategies for maximizing ACT's interprofessional potential, and make recommendations for the future. (Source:PubMed)

Lynn, J., Baily, M. A., Bottrell, M., Jennings, B., Levine, R. J., Davidoff, F., et al. (2007). The ethics of using quality improvement methods in health care. *Annals of internal medicine*, 146(9), 666-673.

Quality improvement (QI) activities can improve health care but must be conducted ethically. The Hastings Center convened leaders and scholars to address ethical requirements for QI and their relationship to regulations protecting human subjects of research. The group defined QI as systematic, data-guided activities designed to bring about immediate improvements in health care delivery in particular settings and concluded that QI is an intrinsic part of normal health care operations. Both clinicians and patients have an ethical responsibility to participate in QI, provided that it complies with specified ethical requirements. Most QI activities are not human subjects research and should not undergo review by an institutional review board; rather, appropriately calibrated supervision of QI activities should be part of professional supervision of clinical practice. The group formulated a framework that would use key characteristics of a project and its context to categorize it as QI, human subjects research, or both, with the potential of a customized institutional review board process for the overlap category. The group recommended a period of innovation and evaluation to refine the framework for ethical conduct of QI and to integrate that framework into clinical practice. (Source: PubMed)

Marsteller, J. A., Shortell, S. M., Lin, M., Mendel, P., Dell, E., Wang, S., et al. (2007). How do teams in quality improvement collaboratives interact? *Joint Commission journal on quality and patient safety*, 33(5), 267-276.

BACKGROUND: The multi-organizational collaborative is a popular model

for quality improvement (QI) initiatives. It assumes organizations will share information and social support. However, there is no comprehensive documentation of the extent to which teams do interact. Considering QI collaboratives as networks, interactions among teams were documented, and the associations between network roles and performance were examined. METHODS: A telephone survey of official team contact persons for 94 site teams in three QI collaboratives was conducted in 2002 and 2003. Four performance measures were used to assess the usefulness of ties to other teams and being considered a leader by peers. RESULTS: Eighty percent of the teams said they would contact another team again if they felt the need. Teams made a change as a direct result of interaction in 86% of reported relationships. Teams typically exchanged tools such as software and interacted outside of planned activities. Having a large number of ties to other teams is strongly related to the number of mentions as a leader. Both of these variables are related to faculty-assessed performance, number of changes the team made to improve care, and depth of those changes. DISCUSSION: The findings suggest that collaborative teams do indeed exchange important information, and the social dynamics of the collaboratives contribute to individual and collaborative success. (Source:PubMed)

McKeon, L. M., Oswaks, J. D., & Cunningham, P. D. (2006). Safeguarding patients: Complexity science, high reliability organizations, and implications for team training in healthcare. *Clinical nurse specialist: The Journal for advanced nursing practice*, 20(6), 298-306.

Serious events within healthcare occur daily exposing the failure of the system to safeguard patient and providers. The complex nature of healthcare contributes to myriad ambiguities affecting quality nursing care and patient outcomes. Leaders in healthcare organizations are looking outside the industry for ways to improve care because of the slow rates of improvement in patient safety and insufficient application of

evidenced-based research in practice. Military and aviation industry strategies are recognized by clinicians in high-risk care settings such as the operating room, emergency departments, and intensive care units as having great potential to create safe and effective systems of care. Complexity science forms the basis for high reliability teams to recognize even the most minor variances in expected outcomes and take strong action to prevent serious error from occurring. Cultural and system barriers to achieving high reliability performance within healthcare and implications for team training are discussed. (Source:PubMed)

Quick, B., Nordstrom, S., & Johnson, K. (2006). Using continuous quality improvement to implement evidence-based medicine. *Lippincott's case management*, 11(6), 305-317.

The importance of implementing evidence-based medicine is being driven by public reporting of outcome data and linking these measures to reimbursement. Most hospitals are faced with many challenges in gaining sponsorship, staffing, creating tools, and reporting of evidence-based outcome measures. This article describes the use of the SSM Health Care (SSMHC) Continuous Quality Improvement model in implementing evidence-based practices at SSM DePaul Health Center, a community hospital member of SSMHC, including successes, opportunities for improvement, and lessons learned. Specifically, the article includes two different processes for data collection and interventions with staff, process requirements for each, and outcome data associated with each model. (Source:PubMed)

Salmon, M. (2007). Guest editorial: Care quality and safety: Same old? *Nursing outlook*, 55(3), 117-119.

Healthcare's increasing focus on quality and safety seem like a "natural" for nursing. The profession has prided itself in being the patient's advocate and the keeper of quality and safety. While nursing has clearly provided consistent and committed leadership in these arenas, it is also possible that exclusive professional ownership of quality and safety may

actually work against the best interest of both nursing and patients. This editorial challenges nursing to reconsider its role in and approach to quality and safety improvement. Building on the important perspectives presented in this issue of *Nursing Outlook*, the author identifies the need for nursing to advance its own professional contributions through building on the shared values and commitments common to health professions. Establishing common ground and extending the concept of care teams to incorporate others beyond direct-care providers are explored as a fundamental component of nursing's work in quality and safety improvement. (Source:PubMed)

Sherwood, G., & Drenkard, K. (2007). Quality and safety curricula in nursing education: Matching practice realities. *Nursing outlook*, 55(3), 151-155. Health care delivery settings are redesigning in the wake of staggering reports of severe quality and safety issues. Sweeping changes underway in health care to address quality and safety outcomes lend urgency to the call to transform nursing curricula so new graduate competencies more closely match practice needs. Emerging views of quality and safety and related competencies as applied in practice have corresponding implications for the redesign of nursing education programs. Nurse executives and nurse educators are called to address the need for faculty development through strategic partnerships. (Source:PubMed)

Smith, E. L., Cronenwett, L., & Sherwood, G. (2007). Current assessments of quality and safety education in nursing. *Nursing outlook*, 55(3), 132-137. Concerns about the quality and safety of health care have changed practice expectations and created a mandate for change in the preparation of health care professionals. The Quality and Safety Education for Nurses project team conducted a survey to assess current levels of integration of quality and safety content in pre-licensure nursing curricula. Views of 195 nursing program leaders are presented, including information about satisfaction with faculty expertise and student competency development related to 6 domains that define quality and

safety content: patient-centered care, teamwork and collaboration, evidence-based practice, quality improvement, safety, and informatics. With competency definitions as the sole reference point, survey respondents indicated that quality and safety content was embedded in current curricula, and they were generally satisfied that students were developing the desired competencies. These data are contrasted with work reported elsewhere in this issue of Nursing Outlook and readers are invited to consider a variety of interpretations of the differences.

(Source:PubMed)

Sweitzer, S. C., & Silver, M. P. (2005). Learning from unexpected events: A root cause analysis training program. *Journal for healthcare quality: Promoting excellence in healthcare*, 27(5), 11-19.

Staff members need appropriate training before the investigation and causal analysis of accidents in any complex system. Otherwise results will be incomplete and will be focused on the least manageable contributors, such as the unsafe acts of frontline operators. This article outlines an incident investigation and root cause analysis workshop developed to address this training need in a spectrum of healthcare settings and reviews feedback from participants. (Source:PubMed)

Varkey, P., Reller, M. K., Smith, A., Ponto, J., & Osborn, M. (2006). An experiential interdisciplinary quality improvement education initiative. *American journal of medical quality*, 21(5), 317-322.

Seven learners, including 2 preventive medicine fellows, 2 family medicine residents, 1 internal medicine resident, and 2 master's-level nursing students participated in an experiential 4-week quality improvement rotation at a major academic medical center. Together they worked on a quality improvement project that resulted in enhanced medication reconciliation in a preventive medicine clinic. Learner knowledge measured on the QI Knowledge Application Tool increased from an average of 2.33 before the start of the rotation to 3.43 (P = .043) by the end of the rotation. At the conclusion, all learners said they

were confident or very confident that they could make a change to improve health care in a local setting. Although this pilot supports the feasibility and potential benefits of interdisciplinary quality improvement education, further research is necessary to explore strategies to implement the same on a larger scale, and to examine the impact on patient outcomes. (Source: PubMed)

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