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Recommendations for Promoting Quality and Safety in Health Care Systems

abstract

Are you a nurse leader or professional development practitioner in a health care facility? This article provides recommendations to promote quality and safety education with a focus on systems thinking awareness among direct care nurses. A key point is error prevention, which requires a shared effort among all nurses.

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Since 2005, health care leaders have been deliberately attempting to reduce patient errors in the United States (Quality and Safety Education for Nurses [QSEN], 2017). Reaching this goal has been difficult. The reality is that medical errors are the third leading cause of death in the United States (Makary & Daniel, 2016). With statistics this high, whether you are a nurse leader or professional development practitioner in a health care facility, it is highly probable that you, a peer, your staff or health care team, or your employer have witnessed, contributed to, or made an error. The need to overcome medical errors through thoughtful prevention has never been more important.

Nurses can minimize error and achieve improved patient outcomes with the identification and application of best practices (Melnyk, Fineout-Overholt, Gallagher-Ford, & Kaplan, 2012). One example for achieving this is with academic–clinical partnerships (American Association of Colleges of Nursing, 2012), where education informs clinicians about best practice recommendations to transform the health care delivery system. The adoption of total system transformation to reduce errors begins with mutually defined practice competencies to measure results (National Patient Safety Foundation, 2015; Newhouse & Spring, 2010). Use of a common language across academic practice settings is ideal for integrating best practice recommendations and maintaining compliance for improved outcomes (Lyle-Edrosolo & Waxman, 2016). In this article, academia offers practice a common language of quality, safety, and systems thinking through operationalized behaviors (i.e., competencies). Nurse leaders and professional development practitioners working in health care facilities can share in complementary roles for advancing systems-level quality improvement initiatives among direct care nurses and for creating a climate of safety (McFadden, Stock, & Gowen, 2015; Warren & Harper, 2017).

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THE QSEN COMPETENCIES AND SYSTEMS THINKING

The six QSEN (2017) competencies were established as a basis for undergraduate nurse educators to:

> Address the challenge of preparing future nurses with the knowledge, skills, and attitudes… necessary to continuously improve the quality and safety of the healthcare systems in which they work. (para. 1)

The six competencies are patient-centered care, teamwork and collaboration, evidence-based practice, quality improvement, safety, and informatics. Patient-centered care involves working with patients to coordinate care based on patient preferences, values, and needs. Teamwork and collaboration requires health care provider teams to function effectively using open communication, mutual respect, and shared decision making to achieve quality patient care (QSEN, 2007). Evidence-based practice is the integration of best clinical evidence into the delivery of optimal care. Qual-

TABLE

RECOMMENDATIONS FOR NURSE LEADERS AND PROFESSIONAL DEVELOPMENT PRACTITIONERS

QSEN Competencies and Systems Thinking	Nurse Leaders	Professional Development Practitioners
Patient-centered care	Ensure that human resources are available for the staff and that budget, strategic planning, and professional accomplishments aim at clinical excellence (Cipriano, 2011; Cody, 2001).	Incorporate patient-centered concepts into clinical education content and competency tools.
Teamwork and collaboration	Expect use of collaborative tools (i.e., TeamSTEPPS) to minimize risks associated with handoffs and across changeovers (Starmer et al., 2014).	Develop interprofessional continuing education (CE) programs for staff's proficient use of collaborative tools (i.e., TeamSTEPPS) (Starmer et al., 2014).
Evidence-based practice (EBP)	Aim for shared goals of quality, efficiency, and implementation of best practice with patient/families, peers, teams, and the organization (Cipriano, 2011).	Use evidence-based adult and organizational learning principles to improve employee performance (Alliance for Continuing Education in the Health Professions, 2017) and promote EBP throughout nursing units and organization (Newhouse & Spring, 2010).
Quality improvement	Use ongoing assessments to anticipate outcomes to prevent errors and by using root cause analysis if errors occur (Merrill, 2015).	Educate nursing staff on data use, monitoring, and performance improvement.
Safety	Design processes that discourage interruptions in high-risk situations (i.e., medication administration) (Raban & Westbrook, 2014; Ritchie, 2013) and enforce use of safety systems (i.e., bar coding, medical technology, wander alarms) (Dykes & Schnock, 2017) to avert errors.	Implement interprofessional CE programs that facilitate open disclosure, collaborative shared review, and the management of errors and near misses (Kiegaldie et al., 2016).
Informatics	Provide current technologies to communicate, manage, mitigate error, and support safe patient care decision making (i.e., EBP guidelines and online references) (QSEN, 2007).	Promote CE programs about the use of current technologies that support safe patient care and decision making (QSEN, 2007).
Systems thinking	Provide shared governance structures (Barden, Griffin, Donahue, & Fitzpatrick, 2011) to allow nurses' input about unsafe systems and solutions.	Educate staff about ways to mobilize macro-level resources to provide safe, efficient patient-centered care (Glynn, 2014) across systems.

Note. QSEN = Quality and Safety Education for Nurses.

ity improvement integrates tools and processes for monitoring data and designing and testing changes. Safety focuses on minimizing risk to patients and increasing individual and system-level performance and accountability. Informatics applies current technology to communicate, manage knowledge, mitigate error, and support decision making (QSEN, 2007).

As QSEN competencies have been embedded into nursing programs via the American Association of Colleges of Nursing *Essentials* series to better prepare nurses to improve the quality and safety of the systems for which they work (Cronenwett et al., 2009), nurses are learning to question systems-related factors that influence quality and safety (Didion, Kozy, Koffel, & Oneail, 2013). According to Dolansky and Moore (2013), systems thinking is critical to applying QSEN competencies because it expands the effects of nursing care beyond individuals to systems-level outcomes. This systems level thinking links human factors and system complexities that lead to unsafe practice (Mansour, 2012). Phillips, Stalter, Dolansky, and Lopez (2016) proposed QSEN mastery as an antecedent to systems thinking because nurses must have self-awareness of personal nursing actions before they can fully comprehend the consequences of their actions onto an entire system. In addition, systems thinking is a precursor to behavior where one nurse's action can influence the success of an organization's quality and safety outcomes (Stalter et al., 2016). Ultimately, systems thinking is an approach used to look at problems broadly, linking interactions and processes (Trbovich, 2014) toward safe practice and improved outcomes (Mansour, 2012).

RECOMMENDATIONS TO PROMOTE QSEN AND SYSTEMS THINKING AWARENESS

How can nurse leaders and professional development practitioners strategize to promote QSEN and systems thinking awareness among direct care nurses? The **Table** uses the common language of QSEN

and systems thinking to highlight evidence-based recommendations for both nurse leaders and professional development practitioners to use within their practices. The recommendations offer complimentary actions between nurse leader and professional development practitioners, which strengthens a climate of quality and safety within health care systems aimed at error prevention.

CONCLUSION

The goal of the direct care nurse is to provide high-quality, evidence-based, patient-centered care. Nurse leaders and professional development practitioners serve as facilitators to the direct care nurse in the prevention of errors. This article provides readers with specific ways for nurses to integrate best practice as it relates to quality, safety, and systems thinking. By using best practice recommendations, nurses can contribute to preventing and reducing errors across the health care system. However, complimentary actions between roles and the use of common education language offers nurses opportunities to strengthen total system transformation toward error reduction.

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