# Learning Outcomes for Patient Safety in Undergraduate Nursing Curricula

CASN ACESI

Canadian Association of Schools of Nursing

Association canadienne des écoles de sciences infirmières

cpsi icsp

Canadian Patient Safety Institute

Institut canadien pour la sécurité des patients





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## PURPOSE

The Canadian Patient Safety Institute (CPSI) and the Canadian Association of Schools of Nursing (CASN) partnered to develop national learning outcomes for graduates of baccalaureate programs of nursing that simultaneously reflect the CPSI interprofessional safety competencies and the guiding principles of the *CASN National Education Framework*.

The aim in delineating patient safety learning outcomes for baccalaureate programs of nursing was to highlight leading practices in this area as they relate specifically to entry-level nursing. This document offers curricular guidance for patient safety concepts to schools of nursing. Achievement of the learning outcomes provides the foundation for graduating registered nurses to integrate CPSI's *Safety Competencies: Enhancing Patient Safety Across the Health Professions Framework* as they move forward in their practice and become more experienced. In addition, the learning outcomes provide more detailed expectations related to patient safety concepts identified in the *CASN Nursing Education Framework.*

It is important to note that the patient safety learning outcomes for baccalaureate nursing graduates are not intended to replace either of these documents, but rather to offer schools of nursing greater specificity in this critical area of health professional practice.

## BACKGROUND

There is widespread recognition that the integration of patient safety competencies in health professional education is vital to the quality of our health care services (British Columbia Nurses' Union, 2015). While relevant harm-related statistics are collected systematically and used to make changes and improve patient safety, evidence continues to indicate that a strong emphasis on patient safety in health care is essential. In 2014–2015, for example, approximately 5.6% of hospital patients in Canada suffered from potentially preventable harm. Moreover, 20% of these patients experienced more than one harmful event during their hospitalization (CIHI & CPSI, 2016).

Health professional education has been a key priority area for initiatives designed to improve patient safety in Canada (CPSI, 2008). Nurses are the largest group of health care providers, spend the most amount of time with patients, and have a large role to play in patient safety. Graduates of baccalaureate programs of nursing must enter practice prepared to apply core knowledge, skills, and attitudes related to patient safety and to contribute to a shift from a culture of blame to one of openness where reporting adverse events or near misses is customary (British Columbia Nurses' Union, 2015). The ensuing learning outcomes will help inform nursing education and, in turn, future registered nurses, who will be working in partnership with patients and families to increase patient safety.

> "Create a just and trusting environment where those providing care and treatment are able to report safety issues and adverse events without fear of retribution, thus reducing the likelihood of repeated future adverse events." (Health Quality Council of Alberta, 2010)

## METHODOLOGY

A modified Delphi process was used to develop the learning outcomes. This process involved a national panel of experts and a series of stakeholder consultations and consensus-building activities.

The first step was to establish an advisory committee of experts from across Canada to guide the process. The next step was to create a draft document of patient safety learning outcomes for nurses, which was developed and worked on by the expert committee over a number of meetings until they reached an initial consensus. The preliminary learning outcomes were then brought to a national stakeholder forum with representation from multiple sectors including nursing regulation, nursing employers, nursing education, patient safety organizations, health care consumers, and patient representatives of Patients for Patient Safety Canada. Participants reviewed and revised each learning outcome using a world café format in which small groups are formed and reformed throughout the day to provide feedback on a specific domain and accompanying learning outcomes. This format allowed for a cross-pollination of ideas, rich discussion, and in-depth input.

Following the stakeholder forum the feedback was collated and reviewed by the advisory committee through a series of meetings using an online platform that allowed the group to edit the document together in real time until they reached a second consensus. The ensuing revised document was then sent out in a validation survey. This survey was distributed to stakeholder forum invitees, attendees, individuals identified by the advisory committee, and some schools of nursing alumni. Respondents were asked to indicate if they felt the learning outcome was essential, very important, somewhat important, or not important or to indicate if they did not know. The survey was sent to 76 people and had a 38% response rate. The advisory committee reviewed the survey results. The benchmark for a re-examination of a learning outcome is any statement that receives less than 70% essential or very important ranking, which none of the learning outcomes received.

## FRAMEWORK

The document is organized into the six domains used in CPSI's *Safety Competencies*:

Domain 1: Contribute to a Culture of Patient Safety
Domain 2: Work in Teams for Patient Safety
Domain 3: Communicate Effectively for Patient Safety
Domain 4: Manage Safety Risks
Domain 5: Optimize Human and Environmental Factors
Domain 6: Recognize, Respond to and Disclose Adverse Events and Near Misses[*]

Detailed learning outcomes accompany each domain. A learning outcome "expresses the lasting changes that must arise in the learner during or following an educational experience" [translation] (Legendre, 2005 as cited in Richard, 2016). There are many benefits of well-defined learning outcomes. They clarify what must be learned in a course or program, offer direction for the selection of learning activities, and provide benchmarks for the assessment of learning (Richard, 2016). The learning outcomes identified in this document provide targets for graduates of baccalaureate programs nursing programs to achieve in the area of patient safety.

[*] "Near misses" is updated from 'close calls' originally used in the CPSI competencies.

# Learning Outcomes for Patient Safety in Undergraduate Nursing Curricula

Domain 1

# Contribute to a Culture of Patient Safety

*Registered nurses contribute to a culture of patient safety and are able to:*

1.1 explain key patient safety concepts and the core elements of a culture of patient safety;

1.2 describe key patient safety processes, including the reporting of adverse events, near misses, methods of analyzing how an adverse event/near miss occurred, and system improvement processes;

1.3 engage in reflective practice to identify the potential risks presented by one's own daily practice and ways to minimize those risks;

1.4 recognize and respond appropriately to potential and actual unsafe situations;

1.5 identify and work within their own level of competency, scope of practice and employee policies and are aware of where to access support if outside their current scope of practice and/or competency;

1.6 review and debrief from adverse events and near misses to address safety issues and provide input to assist with system change;

1.7 demonstrate a commitment to patient safety as a key professional value and an essential component of daily practice;

1.8 demonstrate a commitment to professional learning as a life-long process requiring self-assessment and self-directed education;

1.9 demonstrate critical thinking and respectfully challenge concerns related to patient safety;

1.10 understand and respect the patients' rights, including the right to live at risk, while protecting the safety and well-being of others;

1.11 describe cultural diversity and cultural competency across health settings;

1.12 utilize the codes of ethics for decision making; and

1.13 demonstrate/describe the role of the nurse in patient capacity and consent.

Domain 2

# Work in Teams for Patient Safety

*Registered nurses work effectively in teams for patient safety and are able to*:

2.1 describe the roles, responsibilities, and scopes of practice of each team member, and the expectations and requirements for individual performance;

2.2 communicate effectively within the team to achieve a shared understanding;

2.3 identify key safety issues and priorities inherent in patient centred team practice;

2.4 understand and follow protocols for the team's response to adverse events, including disclosure to patients and families, debriefing and team support;

2.5 use evidence-informed team communication tools to facilitate the improvement of patient safety;

2.6 use appropriate shared clinical documentation to facilitate continuity of care;

2.7 demonstrate commitment to fulfilling their individual responsibilities within the team;

2.8 give and receive constructive feedback; and

2.9 engage the patient and family in their care.

Domain 3

# Communicate Effectively for Patient Safety

*Registered nurses communicate effectively for patient safety when they are able to:*

3.1 use a patient-centred approach to communication;

3.2 describe attributes of effective team communication;

3.3 identify how health literacy affects patient safety;

3.4 tailor their communication to respect cultural diversity and health literacy;

3.5 articulate how protecting patient privacy and confidentiality relate to patient safety;

3.6 engage patients and families in decision making;

3.7 facilitate safe transfers of care;

3.8 uses team communication tools;

3.9 ask questions and seek help from others; and

3.10 advocate for individual patients and for appropriate resources to ensure safety.

Domain 4

# Manage Safety Risks

*Registered nurses effectively manage safety risks when they are able to:*

4.1 recognize high risk situations and safety risks;

4.2 describe approaches and processes associated with risk management;

4.3 describe the proper handling and maintenance of patient care equipment;

4.4 describe infection control, including aseptic technique, hand hygiene, screening and surveillance;

4.5 describe injury prevention, safe patient transport, handling and transfers, and removal of hazards;

4.6 explain the safe administration of medication, recognition of sound-alike and look-alike medications, medication reconciliation and medication safety alerts;

4.7 recognize their accountability in managing safety risks and prioritizes them;

4.8 respond to unsafe situations within their scope of practice;

4.9 respond to safety concerns raised by others; and

4.10 support a safety culture.

Domain 5

# Optimize Human and Environmental Factors

*Registered nurses optimize human and environmental factors for patient safety when they are able to:*

5.1 identify factors that affect their personal well-being, including work-life balance, sleep patterns, and physical and emotional health;

5.2 understand the impact of equipment and systems designs on delivery of care;

5.3 identify environmental factors such as light and sound, work interruptions and technology on personal and patient safety;

5.4 apply critical thinking in decision making;

5.5 explain the effect of work arounds on patient safety;

5.6 demonstrate an appreciation that human performance is affected by one's behaviour within a system affected by resources, culture and policy; and

5.7 recognize the impact of an adverse event on self.

Domain 6

# Recognize, Respond to, and Disclose Adverse Events and Near Misses

*Registered nurses who effectively recognize, respond to, and disclose adverse events are able to:*

6.1 identify biases that affect decision-making and actions;

6.2 identify adverse events and near misses and take action;

6.3 describe current professional and ethical obligations, laws and regulations and policies for the reporting of adverse events;

6.4 provide immediate support to patients and families affected by adverse events and near misses; and

6.5 participate in continuous quality improvement.

# GLOSSARY

| Term | Definition |
|---|---|
| Adverse event | An event that results in unintended harm to the patient, and is related to the care and/ or services provided to the patient rather than to the patient's underlying medical condition. Can also be referred to as a patient safety incident which causes harm to the patient or reached the patient but not discernable harm resulted (adapted from CPSI, n.d.). |
| Codes of ethics | This includes the Canadian Nurses Association Code of Ethics as well as other provincial and territorial nursing codes of ethics as appropriate. |
| Disclosure | A formal process to openly discuss a patient safety incident with the patient, their family, and members of the health care organization (CPSI, n.d.). |
| Health care team | Canada's health care team includes a wide range of regulated, unregulated, and informal or volunteer caregivers. The largest groups of unregulated health care providers are family members, friends, and community volunteers (CIHI, n.d.). |
| Health literacy | The ability to access, comprehend, evaluate and communicate information as a way to promote, maintain and improve health in a variety of settings across the life-course (Government of Canada, 2018). |
| Near Miss | A patient safety incident that did not reach the patient (CPSI, n.d.). |
| Patient-centred care (or patient and family-centred care, client and family -centred care) | An approach to health care planning, delivery, and evaluation, grounded in mutually-beneficial partnerships among health care providers, patients, and families. This approach helps ensure that care is respectful, compassionate, culturally safe, and competent, while being responsive to the patient's needs, values, cultural backgrounds and beliefs, and preferences. Providers share information openly with patients, listen to and respect their needs and expectations, and ensures patients are involved in their own health care decisions. The core concepts are: dignity and respect, information sharing, participation, and collaboration (CPSI, n.d.). |
| Reporting | The communication of information about an adverse event or close call by health care providers through appropriate channels inside or outside of health care organizations for the purpose of reducing the risk of adverse events in the future (CPSI, n.d.). |
| Risk management | Clinical risk management specifically is concerned with improving the quality and safety of health care services by identifying the circumstances and opportunities that put patients at risk of harm and then acting to prevent or control those risks (WHO, 2011). |
| Safety culture | Culture refers to shared values (what is important) and beliefs (what is held to be true) that interact with a system's structures and control mechanisms to produce behavioural norms. An organization with a safety culture avoids, prevents, and mitigates patient safety risks at all levels. This includes a reporting and learning culture (CPSI, n.d.). |
| Team communication tools | Can include briefings, debriefings, assertive language, critical language, common language, closed communication loop (repeating back the verbal instruction or order), active listening and call outs (CPSI, 2011). |
| Workarounds | Workarounds circumvent or temporarily 'fix' perceived workflow hindrances to meet a goal or to achieve it more readily. Behaviours fitting the definition of workarounds often include violations, deviations, problem solving, improvisations, procedural failures and shortcuts (Debono et al., 2013). |

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