Faulty system design and poor system performance have been acknowledged as root causes of medical error (Institute of Medicine [IOM], 2001). Consequently, the IOM supports an ambitious agenda for redesign of the broken healthcare system. Best practices in system redesign require significant involvement of frontline health workers because of their tacit knowledge of the system. Consequently, registered nurses (RNs) are acknowledged as germane to the success of reform efforts (Needleman & Hassmiller, 2009) and are charged with leading transformative change in health care (IOM, 2010). Leading change for quality improvement (QI) requires knowledge and skills beyond the clinical management of patients. Such skills may include system thinking; performance measurement; data management; design, implementation, and evaluation of small tests of change; and human factors engineering. Without these skills, clinicians’ tacit knowledge of the system cannot be translated effectively into the transformative change needed to reduce medical errors and improve quality.

Two IOM reports outlined core competencies for the health professions related to QI and called for focused self-regulation in this area (IOM, 2003, 2010). These competencies were identified as essential to prepare the healthcare workforce to transform the healthcare system. Specifically, the IOM (2003) recommended the health professions integrate QI competencies into oversight processes (licensure, continuing education, certification) related to professional development (PD). Two components of PD exist for RNs: pre-licensure education and continuing professional development (CPD). The initial nursing response to support core competencies in QI focused on pre-licensure PD. Regulation of pre-licensure PD is achieved through approval of nursing programs by state Boards of Nursing and evaluation of nursing programs by national accrediting bodies. Reform in pre-licensure PD is evident in three key documents: Quality and Safety Education for Nurses (QSEN) competency definitions (Cronenwett et al., 2007); Essentials of Baccalaureate Education for Professional Nursing Practice (American Association of Colleges of Nursing, 2008); and National Council of State Boards of Nursing Model Rules (NCSBN, 2012).

Slow Progress

Progress toward adoption of associated changes for pre-licensure PD remains slow and incomplete. Only 13 states explicitly address pre-licensure PD for QI competencies (Meyer, Moran, Cuvar, & Carlson, 2014). Moreover, the nursing response to recommendations related to CPD for the QI competencies is negligible. Two standards in the NCSBN Model Rules (NCSBN, 2012) address CPD expectations: 3.2.1 (e) (maintains competence through ongoing learning and application of knowledge in registered nursing practice); and 5.6.1 (a) (provide evidence of completion of the continued competence requirements specified in 5.6.2). However, no requirements are specified in 5.6.2. Only 36 states require continuing education for relicensure (Yoder-Wise, 2010) and only one state requires content related to the IOM core competencies (Florida, 2 contact hours on preventing medical errors).

Research findings suggest nursing has yet to fulfill self-regulatory responsibilities for QI competencies. Evidence indicates many RNs are not prepared adequately for QI in pre-licensure programs, especially RNs who graduated before dissemination of the QSEN competency definitions (Djukic, Kovner, Brewer, Fatehi, Bernstein, & Aidarus, 2013; Jones, 2017; Sullivan, Hirst, & Cronenwett, 2009). In addition, many RNs are not given experiential learning opportunities to build competence by their employers (Djukic, Kovner, Brewer, Fatehi, & Bernstein, 2013). Finally, RNs have a more negative attitude toward QI competencies (Dungan, 2017).
Necessity vs. Nicety

RNs cannot fulfill 21st century role responsibilities without sustained PD for QI skills. However, compared to CPD for clinical role requirements, CPD for QI is often a lower priority. Evidence suggests RNs prefer CPD activities perceived as relevant to their individual clinical practice area (Nalle, Wyatt, & Myers, 2010). These preferences are supported in RNs’ reports of their most recent CPD program. The most common responses were clinical knowledge and skills and specialty clinical content. No one identified QI as a recent topic. Moreover, in one multi-state study (Djukic, Kovner, Brewer, Fatehi, & Seltzer, 2013), over half of surveyed RNs reported no CPD across 14 QI topics within the previous year.

The complexity of the RN role in today’s healthcare system creates a high demand for CPD across multiple clinical and nonclinical competencies such as QI. In the face of unlimited CPD needs and limited CPD resources (time, money), RNs admittedly must prioritize CPD activities. However, more effective self-regulation is needed to ensure development and sustainability of QI competencies are not overlooked. RNs must accept QI as an essential component of their practice rather than a voluntary, extra-role activity. QI skills must be viewed as necessity rather than nicety.

REFERENCES