Teaching and Learning in Nursing (2015) 10, 39–43

Teaching and Learning in Nursing

www.jtln.org

Patient-centered care and patient safety: A model for nurse educators

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KEYWORDS:
Patient safety;
Patient-centered care;
Teaching safety

Abstract
Safe practice is a basic goal of nursing education. Despite recent highly visible efforts to include safety content within nursing curricula, there is evidence that safety education remains inconsistent. This article develops an evidence-based patient-centered care model with safety as a vital component. It provides a framework and examples for associate degree nursing programs in which safety education can be embedded into existing student experiences and focused on the patient in an efficient, realistic manner.

Preparation of students to provide safe, high-quality nursing care is a universal underpinning of nursing education. A survey conducted by the National Council of State Boards of Nursing (2012) found a high degree of concurrence among nurse educators, newly licensed registered nurses, and nursing supervisors in the identification of selected safety content as the most important knowledge for nurses. Likewise, the Quality and Safety Education for Nurses (QSEN) initiative pointed out the vital nature of a set of competencies (Table 1) to promote safe patient care (Cronenwett et al., 2007). Extensive outreach and training conducted within the QSEN initiative stimulated the inclusion of explicit quality and safety learning outcomes into many nursing curricula. Yet, despite this promising progress, recent evidence suggests that learning experiences to meet quality and safety outcomes are inconsistently incorporated into many of our nursing programs (Tella et al., 2014).

There is little in the literature to suggest reasons for the apparent omission of quality and safety learning experiences from many programs of nursing education. One obvious consideration is that safety education is in competition for time and space in the curriculum with other emerging, evidence-based content. However, perhaps, there are less obvious issues that may lead us to instinctively emphasize other educational content over quality and safety. One of these issues might be that safety interventions are often constructed according to an industrial safety model, complete with clipboards, checklists, and feedback loops (Jorm, Dunbar, Sudano, & Travaglia, 2009). As we search for ways to implement expert recommendations that we contextualize nursing education within actual experiences of the patient (Benner, Sutphen, Leonard, & Day, 2010), we are finding it difficult to add one more classification system, checklist, or hierarchy of concepts to our classroom and clinical experiences. How do the seemingly task-oriented, mechanistic approaches to safety management fit within the nurse–patient relationship that we seek to foster?

1. The patient safety paradigm refocused

One answer to the question regarding safety's place in nursing's world view is to conceptualize safety as one aspect

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http://dx.doi.org/10.1016/j.teln.2014.08.002
1557-3087/

Table 1

QSEN competencies
Patient-centered care
Teamwork and collaboration
Evidence-based practice
Quality improvement
Safety
Informatics

Note. Summarized from Cronenwett et al. (2007).

of a larger culture or model. Rather than viewing safety as predominantly related to surveillance, reminder systems, checklists, and risk assessments, perhaps we might view safety as one ongoing component of a multifaceted approach to personalized patient care. Such a conceptualization was found in a systematic, comprehensive meta-analysis of the literature seeking to describe a culture of safety (Sammer, Lykens, Singh, Mains, & Lackan, 2010). This review identified seven properties of a culture of safety. These properties are listed in Table 2.

These identified properties of cultures of safety are similar and complementary to the quality and safety core competencies for nurses identified in the QSEN project (Cronenwett et al., 2007). Both of these approaches also overlap with evolving definitions of patient-centered care, which has been described as the process of partnering with patients and their families, involving them in their own health care decisions (Warren, 2012). In the often-quoted words of visionaries promoting patient empowerment, patient-centered care is simply, "Nothing about me without me" (Delbanco et al., 2001). Table 3 lists the core components of patient-centered care (Institute for Patient & Centered Care, 2010).

Although the competencies and identified components of safe, patient-centered care (Tables 1–3) offer important content for nurse educators, they seem to call for an organizing framework to guide inclusion into nursing educational programs. Without such a model, we are at risk for simply teaching the suggested characteristics or competencies as knowledge to be memorized or as add-on content within an already full curriculum.

In keeping with Benner et al.'s (2010) recommendation that educators continue to find ways to focus students upon the experiences of patients, it is proposed that we use a model that places patient-centered care at the core, with safety being one aspect of a patient-centered approach. Such a model is

Table 2

Properties of a culture of safety
Leadership
Teamwork
Evidence-based
Communication
Learning
Just
Patient-centered

Note. Summarized from Sammer et al. (2010).

Table 3

Components of patient-centered care
Respect and dignity
Information sharing
Participation
Collaboration

Note. Summarized from Institute for Patient and Centered Care (2010).

depicted in the Patient-Centered Safety Model (Fig. 1), which combines the components of patient-centered care, the QSEN competencies, and the properties of cultures of safety. The model is arranged to suggest interactive, multidirectional relationships among the various components.

It is apparent in the model that some of its components extend beyond the model's core. That is because it is recognized that there are times that in-depth study may be required to increase understanding of a particular concept or activity. However, these avenues of study and inquiry are outside of the direct nurse–patient interaction and are not part of the primary focus upon the experience of the patient. In an associate degree nursing program, such study might be reserved for special projects or elective courses.

Further examination of this model may offer one additional answer to our original question regarding why some schools of nursing do not appear to consistently teach safety content. Perhaps many educators have, as depicted in our model, embedded safety content so seamlessly within their student–patient experiences that descriptions of individual learning experiences do not reflect the culture of safety to which students are actually exposed. If this is the case, educators who apply these strategies are encouraged to more fully document and share them. For those of us who have not yet imbedded a patient-centered culture of safety into our students' educational experiences, or for those who seek additional strategies, the model and exemplars in this article may be of assistance. It is to be noted that all components depicted in the model have been identified as working synergistically among other components to drive high-quality, satisfying patient experiences. This article focuses on two of the components: patient-centered care and patient safety.

2. Patient-centered care and safety

Patient-centered models of care have often been found to increase patient satisfaction, nurture trust in clinicians, and enhance perceived adequacy of communication (Walton & Barnsteiner, 2012). In addition, evidence has been emerging for over a decade linking patient-centered care to positive safety outcomes, including fewer adverse events and lower rates of complications (Ponte, Connor, DeMarco, & Price, 2004; Warren, 2012). In fact, the Institute for Healthcare Improvement identifies patient safety as one driver of