Quality and Safety Graduate Competencies in Psychiatric Mental Health Nurse Practitioner Education

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Education of the psychiatric mental health nurse practitioner (PMHNP) is undergoing massive change, partially driven by practice requirements and national certification changes, the development of new nurse practitioner competencies, and the development of the graduate quality and safety in nursing (QSEN) competencies. We are in the middle of a paradigm shift of expectations, not only just from these new competencies but also from the context of care and the impact PMHNP graduates will have on policy and health care delivery in the future. In this review article, the authors will discuss the general categories of the graduate QSEN competencies and how they relate to PMHNP education, competency development, and the application to curricular development in PMHNP programs across the United States. Importantly, these changes into PMHNP education, while remaining true to the fundamental tenants of advanced practice psychiatric nursing, prepare the PMHNP to meet the challenges of health care reform and service delivery.

QUALITY AND SAFETY are not new issues to psychiatric nursing or to advanced practice psychiatric nursing. For a myriad of reasons, safety has always been an important issue for inpatient psychiatric treatment, and nurses are the main architects of this dimension of care (Johnson & Delaney, 2007). A key component of safety has been both the reduction of violence and issues surrounding the use of seclusion and restraint. The latter is an issue becoming more important with each Joint Commission (JC) requirement (JC, 2012). Psychiatric nurses also understand that concerns around quality and safety extend beyond restraint issues and preventing medication errors. This understanding has been considerably informed by the graduate-level Quality and Safety Education for Nurses (QSEN) competencies, which were developed and approved on January 17, 2012 (http://www.qsen.org/ksas_graduate.php). A PubMed search revealed limited information regarding how graduate QSEN competencies have been applied in the education of psychiatric mental health nurse practitioners (PMHNP). In this article, we will discuss the general categories of the graduate QSEN competencies and how they relate to PMHNP education and competency development and application to curricular development in PMHNP programs across the United States.

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BACKGROUND

A national advisory board, representatives from advanced practice professional organizations, and QSEN faculty met, defined, developed, and implemented the graduate QSEN competencies to be used as a resource for curriculum development (Cronenwett et al., 2009). The major categories include patient-centered care, teamwork and collaboration, evidence-based practice (EBP), quality improvement (QI), safety, and informatics. Key areas of focus within each of these categories included knowledge, skills, and attitudes (KSAs; Cronenwett et al., 2009). Research is just beginning to emerge that depicts safety strategies used by nurses in the mental health sector that align with QSEN competencies (Jeffs, Rose, Macrae, Maione, & MacMillan, 2011).

Advanced practice psychiatric nurses have translated QSEN competencies into their everyday practice for decades via their work within the therapeutic relationship, an inherently patient-centered model (National Panel for Psychiatric Mental Health Nurse Practitioner Competencies, 2003). The PMHNP has always had to use particular KSAs as relationships with patients are developed and maintained, especially when validation and change are encouraged. Adoption of QSEN-type competencies was recently formalized in the 2003 development of PMNNP competencies (National Panel for Psychiatric Mental Health Nurse Practitioner Competencies, 2003). Within these competencies are evidences for patient-centered care with the domain of the nurse practitioner (NP)–patient relationship, for team work and collaboration within the domain of managing and negotiating health care delivery systems and, finally, for quality with the NP competency domain of monitoring and ensuring the quality of health care practice. The QSEN competencies bring enrichment and new areas of focus for the education and practice of the PMHNP.

The graduate QSEN competencies bring a renewed focus on teamwork and collaboration, QI and patient-centered care, and a new focus on EBP and informatics. Fetter (2009) noted that issues tied to QSEN competencies such as advocacy, empowerment of patients, integration of best evidence, and QI are all part of a paradigm shift in psychiatric nursing.

This shift is also evidenced in NP education where a revised set of core competencies for all NPs has just been developed and published (NONPF, 2011). These NP core competencies include a focus on scientific foundation, leadership, quality, practice inquiry, technology and information literacy, policy, health delivery system, ethics, and independent practice competencies. In addition to the foci on quality, safety, teamwork, EBP, and QI, there is also an expansion of expectations for analysis of data for the improvement of care, reflective leadership, translation of knowledge into practice, an emphasis on ethical decision making, and an emphasis on the independent role of the NP. The QSEN competencies informed many of the NP core competencies. How will these changes be applied to PMHNP education? In the next several sections, the authors will discuss the integration of QSEN, the NP core competencies and how these relate to PMHNP education.

Patient-Centered Care

One of the core QSEN competencies is the delivery of patient-centered care. Providing patient-centered care is depicted as a process that begins with recognition of the patient as the source of control in care planning; a process that results in a treatment plan based on the patient's preferences, values, and needs (http://www.qsen.org/ksas_graduate.php). Its depiction in mental health treatment mirrors the QSEN definition but emphasizes respect for the individual, unconditional acceptance, and support of the individual to live his or her own life (Council on Quality and Leadership, 2010). Within both definitions is a focus on how patients define their needs; a focus that should bring about a subtle shift in power because patients assume greater control of the aims and outcomes of treatment. This shift would also be visible in the outcomes nurses measure because they encompass each patient's goals for treatment.

Patient-centered care is intuitively correct; the balance of power in traditional health care has certainly been lopsided for decades. It is also an initiative that is quickly reaching a tipping point. The tipping point is that place where a phenomenon gains acceptance to become an influential trend (Gladwell, 2002). The processes and mechanisms that are creating this tipping point are clear. Patient-centered care has the power of context; it arrives at the right time and meshes well with a core idea of the health care reform agenda, probably best depicted as the Triple Aim (Berwick, Nolan, &Whittington,