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Nursing Faculty's Integration of Quality and Safety Competencies as a Curricular Framework

Florianne Mereigh-Frederick
Walden University

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Review Committee

Dr. Cheryl Keen, Committee Chairperson, Education Faculty

Dr. Laura Weidner, Committee Member, Education Faculty

Dr. Paul Englesberg, University Reviewer, Education Faculty

Chief Academic Officer
Eric Riedel, Ph.D.

Walden University
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Abstract

Nursing Faculty's Integration of Quality and Safety Competencies

as a Curricular Framework

by

Florianne Mereigh Frederick

MPH, New York Medical College, 2003

BSN, College of New Rochelle, 1995

Dissertation Submitted in Partial Fulfillment

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Abstract

The call to better prepare nurses in safety and quality performance resulted from the concern of the Institute of Medicine regarding egregious gaps and errors in U.S. hospitals that resulted in serious injuries and patient deaths. Quality and safety education for nursing (QSEN) competencies were set forth in 2005 to enhance nursing curricula and nursing students' preparation for practice; however, QSEN's integration and implementation have been gradual and inconsistent. This qualitative interpretive study was guided by Senge's principles of the learning organization and Benner's professional development model. Using face-to-face interviews, the perspectives of 9 full-time nursing faculty members at 2 private nursing colleges in the Northeast United States were obtained about QSEN integration into their curriculum. Data analysis employed the use of open in-vivo coding, categorizing, and the formation of themes. The results indicated that QSEN integration was perceived as complex and daunting due to faculty's limited knowledge about QSEN, lack of adequate preparation to develop and employ instructional strategies, lack of adequate time to teach, and limited learning opportunities at clinical sites to develop competencies such as teamwork and collaboration and informatics. Meaningful reform in nursing education may occur as leaders engage faculty members in meaningful dialogue to better understand the complexity and challenges of QSEN integration, including faculty members' needs for successful implementation. Nursing students may then be better trained to understand the nature and consequences of human and system errors and appreciate higher standards of care that will result in a decrease in preventable injuries, medication errors, and patient deaths.

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Chapter 1: Introduction to the Study

Introduction

A series of national reports in the United States at the turn of the 21st century revealed multiple incidences of preventative injuries and egregious gaps in the U.S. health care system (Brown, 2010; Jones, 2013; Piscotty, Grobbel, & Tzeng, 2011). These gaps resulted in low quality care, with poor outcomes of care and patient deaths (Jones, 2013). Considering these reports, in 2003, leaders in healthcare such as the Institute of Medicine (IOM; now the National Academy of Medicine) set forth an imperative for social change proposing quality and safety competencies as a new framework to prepare emerging health professionals, such as nurses, for practice (Sherwood & Zomorodi, 2014). Within the clinical setting, numerous initiatives, such as the creation of safety cultures, high reliability organizations, and quality improvement programs, were geared toward promoting standards for safer and higher quality care (Disch, 2012). Nurses comprise a large sector in healthcare, have the potential to effect the greatest change, and should be adept in knowing what constitutes good care and demonstrate the same (Berndt, 2014; Cronenwett et al., 2007; Jones, 2013).

The need in academic institutions to reform and better equip emerging health professionals, such as nursing students, was proposed and supported by both national and accrediting organizations, such as the IOM, and the Joint Commission; federal and state agencies such as the Center for Medicaid and Medicare; and leading nursing organizations that include the National League for Nursing (NLN), National Council State Boards of Nursing (NCSBN), the Carnegie Foundation for Health Education, and

the American Association of Colleges of Nursing (AACN); (Didion et al., 2013; Disch, 2012; Morris & Hancock, 2013; Phillips et al., 2016). Despite students' success in obtaining licensure for nursing practice, the standard nursing curriculum proved inadequate and limited in scope to adequately prepare students for new and emerging safety standards for higher care quality in the workplace (Barton et al., 2009). Because of expectations of higher standards of practice, nursing colleges also sought to reassess curricula by identifying gaps and introducing new pedagogies that addressed safety and quality concepts congruent with contemporary practice standards.

The introduction of a quality and safety education for nursing (QSEN) curriculum became a national initiative to reform nursing education. Based on principles of safety and quality, the QSEN curriculum develops prelicensure nurses' knowledge, skills, and attitudes in specific competency areas of patient-centered care, teamwork and collaboration, evidenced-based practice (EBP), quality, safety, and informatics (informational technology (Cronenwett, et al., 2007). Funded by the Robert Wood Foundation in 2005, a QSEN faculty group led by Dr. Cronenwett and Dr. Sherwood adopted, developed, and defined six competencies from the original IOM competencies and applied them to the discipline of nursing (Brown et al., 2010). Each one of these QSEN competencies is comprised of three elements related to knowledge, skills, and attitudes. The QSEN model was conceptualized as a bridge connecting nursing education to clinical practice and the realities of the workplace (Jones, 2013; Sherwood & Zomorodi, 2014; Sullivan, 2010). The goal of QSEN has been to serve as a wide framework from which faculty can interpret, develop, and integrate the competencies,

reform the nursing curriculum, and enhance the preparation and readiness of future nurses (Berndt, 2014; Brown et al., 2010; Disch, 2012; Sherwood, 2011).

However, the process of integrating quality and safety principles to develop prelicensure nurses' knowledge and skills was found to be daunting for faculty due to their lack of knowledge and understanding of safety concepts and pedagogy, lack of preparedness to teach safety concepts, differences in perspectives, and levels of resistance regarding the integration of QSEN in curricula (Bryer & Peterson-Graziose, 2014; Cronenwett, Sherwood, & Gelmon, 2009; Pollard et al., 2014). Faculty members' knowledge and understanding of QSEN concepts and principles, as well as their buy-in, are critical for true curricular reform and execution, to enhance learning outcomes, and for developing high performing practitioners for practice (Bryer et al., 2014). The need therefore to obtain faculty members' perspectives regarding their experiences integrating QSEN may confirm or provide new knowledge regarding facilitating and inhibiting factors that may enhance future curricula change activities.

In Chapter 1, I will describe the background of the state of the health care environment at the turn of the 21st century, the call for higher performance in nursing practice, and the recent introduction of the IOM and QSEN competencies for safe practice among health professionals such as nurses. I will explore the gap that existed between the mandate for the teaching and the learning of safety science versus its integration and use in nursing education. Additionally, I will discuss my conceptual approach that framed my research problem and question. My conceptual approach encompassed the concept of systems in relation to its influence on the shaping, structure,

and orientation of QSEN integration in nursing education. In this study, I also employed a developmental approach from a novice-to-expert perspective to better comprehend faculty members' professional development in safety science knowledge and concepts. I will further discuss definitions, assumptions, scope, limitations, and delimitations. Finally, I will elaborate on the significance of using quality and safety education for nurses as a curricular framework.

Background

The call for radical transformation and social change within the education and practice of nursing and other health professionals came because of several sobering reports from the IOM at the turn of the 21st century (Bryer & Peterson-Graziose, 2014; Jones, 2013; Sherwood & Zomorodi, 2014). These reports alluded to the numerous amount of yearly medication errors, adverse drug incidents, and preventable deaths and became the basis for proposing reform in educational systems and the subsequent introduction of quality and safety science for health care professionals (Sherwood, 2011; Sherwood & Zomorodi, 2014). Brown et al. (2010, p. 115) reported that in 2003, the IOM advocated for the inclusion of innovative competencies into the curricula of health education programs and posited a reeducation of health professionals that would significantly impact students' professional identity. As explained by Sherwood and Drenkard (2007), "no vision for an improved system can be implemented without preparation of personnel" (p. 151). Pohl et al. (2009) found that nursing education and other health disciplines were challenged to prepare graduates who could demonstrate

skills that are patient focused and collaborative and were able to apply scientific evidence and use technology to enhance the safety and quality of care.

The demand for the inclusion of safety science into curricula has spread across all health care disciplines including medicine, nursing, and pharmacy (Mansour, Skull, & Parker, 2015; Zeind, Blagg, Amato, & Jacobson, 2012). Supporting this initiative in nursing are the NCSBN and the AACN. The former has integrated components of quality and safety competencies into the National Council Licensure Examination for Registered Nurses (NCLEX) test plan, while the latter has integrated quality and safety principles into its educational standards for baccalaureate and advanced nursing degrees (Cabaniss, 2014; Sherwood, 2011). In addition, the NLN adapted concepts of quality and safety into its educational competency model with specific program outcomes (Pollard et al., 2014).

A subsequent QSEN educational model for competency development in support of the IOM's proposal to transform health professions' education was introduced by a board of quality and safety nursing faculty experts and funded by the Robert Wood Johnson Foundation (Sherwood et al., 2007; Sullivan et al., 2009). The goal of QSEN was to enhance nursing curricula to reflect contemporary practice and support faculty development so that nursing programs can adequately prepare emerging nurse professionals with the knowledge, skills, and attitudes that can elicit higher performance in safety and quality in areas where they work (Bryer et al., 2014; Sullivan et al., 2009). QSEN also posited a broader framework to elicit diverse approaches to interpreting, developing, and implementing the competencies within various undergraduate and graduate nursing program curricula (Sherwood & Zomorodi, 2014).

Subsequent redesign initiatives in the health care industry promoted by national and federal agencies also led to the introduction of safety standards, regulations, and new perspectives on what constitutes safe and high-quality care (Sherwood and Drenkard (2007). Because nurses play a pivotal role in health care and have a significant impact on care quality, the urgency to transform nursing curricula to match the changing paradigm in health care was an imperative to ensure that the curriculum aligned with the realities of practice, met employer expectations, and enhanced the transition experience for new graduates at the onset of practice (Sherwood and Drenkard (2007). How student nurses are prepared for practice directly impact their attitudes about safety and quality standards, their perception of readiness for practice, and their future performance at the bedside.

Different from the traditional nursing curriculum that used a sequential and progressive learning of scientific nursing knowledge and skill in the physical and behavioral sciences of acute and chronic medical conditions, the QSEN model incorporated the nursing science of adults and pediatrics within the context of a three-tier domain of progressive levels of knowledge, skills, and attitudes for each of six competencies in areas of patient-centered care, teamwork and collaboration, evidence-based practice, quality, safety, and informatics (Barton et al., 2009). The QSEN model also posited an overarching definition regarding the essence of the six competency areas:

- The patient-centered care competency is recognized as the ability of the learner to understand the role and function of a patient or his or her designee as the locus of control and active participant during the provision and

management of coordinated care and that care is grounded in patient's preferences, values, and needs (Cronenwett et al., 2007).

- The teamwork and collaboration competency is the ability of the learner to demonstrate socially organized skills, such as open communication, mutual respect, and collaborative decision-making, within nursing and among interprofessional teams that result in higher care quality (Cronenwett et al., 2007).
- The evidence-based practice competency is the ability of the learner to incorporate current scientific evidence in collaboration with clinical expertise and patient and family preferences and values to deliver optimum care (Cronenwett et al., 2007).
- The quality improvement competency is the ability of the learner to use statistics to monitor and evaluate care processes and outcomes and employ improvement methodology by introducing and testing methods to continuously enhance the quality and safety of health care systems (Cronenwett et al., 2007).
- The safety competency is the ability of the learner to identify and minimize risk that threatens harm through higher individual performance and development of effective systems policies and processes (Cronenwett et al., 2007).

- The informatics competency is the ability of the learner to use information and technology to communicate, manage information, decrease error, and enhance decision-making (Cronenwett et al., 2007).

The QSEN educational model also posited a systems approach to care quality outcomes (Barton, Armstrong, Preheim, Gelmon, & Andrus, 2009; Dolansky & Moore, 2013). A systems approach embraces a comprehensive approach to patient care with the understanding that outcomes of care do not originate nor end with an individual but are largely impacted by the interaction of social and system structures and processes within an organization (Dolansky & Moore, 2013; Paquet, Courcy, Lavoie-Tremblay, Gagnon, & Maillet, 2013). Learning what the prevailing concepts and mindsets are surrounding quality and safety, including the impact of systems processes on patient care, broadens the scope of the novice nurse to understand how outcomes are linked to and influenced by system and human factors. In addition, demonstration of skills and knowledge of systems improves the preparation of students by acquainting them with the realities of workplace practices (Phillips et al., 2016; Sherwood et al., 2007).

Brown et al. (2010), Cabaniss (2014), and Sherwood and Zomorodi (2014) alluded to nursing education restructure as a method to reshape the minds of emerging nurse professionals to the new landscape and culture of patient safety and quality in the workplace. Although, historically, safety had been an integral and embedded element of nursing science learning, safety principles were not emphasized as an explicit science in relation to the concept of systems and how system factors influenced the outcomes of care (Mansour et al., 2015). Traditional learning, however, proved inadequate in

preventing gross medical errors. Sherwood and Zomorodi and Phillips et al. (2016) proposed that use of QSEN as a curricular framework in nursing education allowed for purposeful learning of specific safety concepts, principles, and content that serve as foundation to prepare students to work in a culture of safety – a defining characteristic of the 21st century health system. Additionally, learning these competencies prepared nurses for leadership roles as they adapted concepts of systems thinking and understood the dynamics of how systems factors work to elicit and foster change in the workplace (Dolansky & Moore, 2013).

Regarding inclusion of the QSEN curriculum into clinical practicum nurse training, Cabaniss (2014) supported the notion that mastery of the QSEN competencies required the use of additional instructional strategies including the use of generic didactic approaches and dedicated individual courses. Additionally, Cabaniss thought that the QSEN curriculum could also serve as a resource to guide curricular development during transition to practice and other continuing education programs (p. 182). Armstrong, Spencer, and Lenburg (2009) and Kim, Lee, Eudey, Lounsbury, and Wede (2015) also advocated QSEN integration as a catalyst to enhance clinical performance as well as leadership and socialization skills of new nurses. Although there was consensus regarding the need to restructure nursing education through the inclusion of QSEN competencies, central to their analysis of the transformational process was the role of nursing faculty and their stance regarding QSEN and the curricula change process.

Finally, successful integration of QSEN competencies into the nursing curriculum was associated with faculty development, faculty collaboration, and a willingness to shift

from the status quo to embrace a broader and larger vision (Bryer et al., 2014; Cabaniss, 2014). Faculty also influence how learning is structured and implemented and impact students' learning experiences (Armstrong et al., 2009). However, minimal research regarding faculty perspectives about the QSEN curricular reform process has been conducted, including how to support and manage the novice-to-expert learning process for faculty to effectively teach and develop a generation of nurse change agents.

Problem Statement

The IOM's urgent call to restructure and realign health professionals' curricula among emerging nurse professionals in principles of quality and safety was introduced as one way to decrease and mitigate errors and improve healthcare outcomes in the clinical setting (Cabaniss, 2014; Morris & Hancock, 2013). In support of the IOM, the QSEN curriculum established six core competencies as a framework in nursing curricula for acquiring the knowledge, skills, and attitudes needed to demonstrate higher performance in patient care quality and safety. Although the teaching of safety has been embedded and implied in nursing, a new holistic and explicit approach to teaching and evaluating students' knowledge and skills in error prevention and quality care principles became an imperative in nursing education (Cronenwett et al., 2009; Mansour et al., 2015; Sherwood, 2011).

As educators of the largest healthcare workforce, nurse faculty play a critical role in creating, implementing, and applying curricular changes to the classroom and clinical practicum setting for effective learning (Armstrong et al., 2009; Pollard et al., 2014). Faculty engagement is therefore essential for curriculum development and

implementation. In seminal research, Cronenwett et al. (2009) found, however, that although faculty acknowledged that it is essential to teach the knowledge, skills, and attitudes aspects of the QSEN competencies, they admitted to not having the expertise to develop and implement course content and to assess learning. In addition, the researchers found that changing what faculty perceive as essential to achieve success in licensure exams was a challenge for QSEN faculty members during curricula reform activities. Research also revealed that faculty expressed a lack of training and preparedness to teach some of the quality and safety competencies and noted confusion regarding the definitions of competencies and difficulty with developing pedagogical strategies prior to receiving training workshops (Bryer et al., 2014; Cronenwett et al., 2009; Morris et al., 2013; Pollard et al., 2014; Sherwood, 2011).

Faculty members' misunderstanding of QSEN concepts can lead to teaching inaccurate content that impacts students' comprehension and understanding of QSEN and reveals a gap between faculty's knowledge and preparedness to teach and faculty's role expectation to proficiently integrate and implement the QSEN competencies (Morris et al., 2013). Although studies have assessed the extent of QSEN integration into nursing curricula (Pollard et al., 2014; Zeind et al., 2012); the impact of QSEN integration on nursing students' competency development (Jones, 2013; Miller et al., 2009); and methods of QSEN integration (Manning & Frisby, 2011; Pohl et al., 2009), faculty perspectives about the integration process have been minimally explored. Exploring faculty perspectives of integrating QSEN into curricula will identify gaps, provide additional knowledge regarding barriers and facilitating factors, and find areas needing

further development to improve the quality of nursing education for a new generation of emerging nurse leaders.

Purpose of the Study

The purpose of this basic qualitative interpretive study was to understand the perspectives and attitudes of faculty as they integrated QSEN competencies into their existing curriculum at the School of Nursing at two private colleges in the Northeast United States. In this study, I examined and described personal and system related factors that influenced faculty members' attitudes and responses during QSEN integration to reform the nursing curriculum. Individual perspectives and attitudes are influenced by personal and system related factors and understanding how these factors influence the curricular change process may provide knowledge to inform future curricula reform initiatives (Hickey, Forbes, & Greenfield, 2010; Senge, 2006).

Research Question

The following research question guided this study: What are faculty members' perspectives regarding integrating quality and safety education for nurses (QSEN) competencies as a curricular framework for a nursing program curriculum? Additional subquestions were: What are faculty members' attitudes concerning curricular change? and How do faculty members perceive their role in curricular change?

Conceptual Framework

The conceptual framework I used in this study for interpreting faculty perspectives integrating QSEN competencies into a nursing program curriculum was based on Senge's (2006) principles of a learning organization. Additionally, Benner's

(2001) novice-to-expert developmental learning concept provided a context for me to interpret faculty's experiences and responses as they learned QSEN concepts with the expectation to achieve competence and expertise for instruction. The influence of human and system factors posited by Benner and Senge provided a comprehensive frame to interpret study findings and conclusions.

Using Senge's (2006) systems thinking and its foundational principles of learning organizations provided me with a framework and context to develop my research question and supported my examination of faculty members' perspectives about system factors (e.g., communication and decision making through the interview questions and how these factors influenced the curricular change and teaching process). Investigating systems variables such as faculty members' assumptions (mental models) regarding the need for curricular change, the QSEN competencies, perceptions of their role in the change process, and their perceptions of personal readiness to teach QSEN led to knowledge that can inform future curricular change processes and the quality of nursing education. Additionally, the use of Senge's principles served as a supporting frame to explain and validate the study results and conclusions.

Faculty members' knowledge and expertise impact on students' learning outcomes, their readiness for practice, and development of their professional identity. Benner's (2001) concept is based on the Dreyfus model assumption of skill acquisition that skills are perfected or transformed through experience and mastery (p. 38). Both Senge's (2006) principle of personal mastery and Benner's novice-to-expert concept were based on the premise that newly learned principles must be tested, refined, and developed

through continuous use and lifelong learning. The need to understand what factors influence faculty members' skill development in quality and safety concepts are essential to facilitate effective teaching and learning. Additionally, the extent of curricular change may depend on degree of faculty level of expertise as well as their engagement in continuous dialogue and feedback.

Nature of the Study

In this study, I employed a basic qualitative interpretive design (see Patton, 2002) using open-ended, semistructured, face-to-face interviews with nursing faculty members at two private colleges to better understand the thoughts, perspectives, and voices of faculty (see Merriam, 2009). Qualitative research is conducted in normal settings where daily events and activities and human responses occur; qualitative data also focuses on processes as they occur including the outcomes (Creswell, 2009, p. 195). One method of obtaining rich qualitative data is to explore and understand how individuals interpret and make sense of a situation; through interaction with the participants, I was better able to understand the perspectives of faculty (see Creswell, 2009). The data I obtained were coded and analyzed through thematic analysis by extracting and formulating emerging themes and descriptions regarding faculty perspectives of QSEN integration. The themes were further developed and evaluated within the context of the principles of a learning organization and served as a basis to inform policies and practices of future curricular reform initiatives (see Creswell, 2013; Patton, 2002).

Definitions

Learning organizations: An organization that allows their employees to use their analytical skills and creative abilities to challenge and develop innovative ideas and thoughts that produce effective results and accomplishments (Senge, 2006, p. 3).

Mental models: Deeply ingrained assumptions, values, and beliefs that frame individual perspectives of the world and how these perspectives influence performance and behavior (Senge, 2006).

Personal mastery: An ongoing process of personal discipline of an individual expanding their ability through continuous learning to produce desired and rewarding results (Senge, 2006)

Systems thinking: A language and a holistic way of thinking and understanding an entity or system by examining the function, interdependence, and dynamic interactions of individual parts and how each part influences each other to shape processes, patterns, and complex outcomes (Phillips et al., 2016; Senge, 2006).

Assumptions

I assumed that all participants understood the questions asked, disclosed the truth about their experiences, and requested for clarity where needed. I also assumed that participants understood the purpose and intent of this study such that the data collected provided substantive information congruent with the purpose and intent of the study. As a part-time member of the faculty at one of the colleges where this research was conducted, I employed high ethical standards that related to respect and protection for all participants, including in data collection and analysis. I also assumed that participants

were aware that none of the data obtained would be used for any other purpose other than to obtain knowledge on faculty perspectives about the QSEN integration process. Providing truthful data adds credibility to any study and its findings, resulting in outcomes that can potentially inform and improve future curricular change processes (see Paton, 2015).

Delimitations

In this study, I focused on examining faculty experiences of integrating QSEN competencies into a nursing program curriculum. I integrated the QSEN competencies as a framework for defining course objectives in classroom, clinical practicum, simulation, and as a benchmark for evaluating student learning outcomes. Participants included only nursing faculty members who worked at two private nursing colleges in the Northeast United States and participated in the QSEN integration process at each of their respective colleges. The results of this study may be applicable in similar settings in nursing education where curricular change is elicited and is executed by nursing faculty.

To align this study with the purpose, theoretical framework, and research questions, I developed the interview questions to examine faculty members' attitudes, buy-in, and readiness for change in response to the global call for system change in nursing education in how nursing students are prepared for practice. Additional questions addressed how faculty members perceived their role in the curricular change process, the QSEN curriculum model versus the generic nursing curriculum in relation to enhanced standards of learning and performance in safety and quality concepts, and what faculty members perceived as gaps and facilitating factors in the curricular change process that

may inform future curricular reform activities. I further analyzed and interpreted the data findings within the context of the theoretical framework, the research question, and purpose of the study.

Limitations

The study findings were limited to include only data collected from nursing faculty members who participated in QSEN integration at the nursing department of two private colleges on the east coast of the United States. Because I was a faculty member at one of the colleges at the time of the study, familiarity with participants at that site may have resulted in potential bias during the data collection from questions that were perceived by participants as sensitive and offensive that could have been a potential source of rich data. My familiarity with participants may have also resulted in biased responses due to participants' reluctance to disclose data that they perceived as negative or sensitive, and either I or the participant may have assumed understanding of all questions and statements which may not have been the case. In addition, my personal bias regarding the importance of learning quality and safety concepts may have influenced how I designed the study and collected and analyzed the data. Due to variability in nursing curricula and how QSEN is applied in different nursing institutions, the resulting data may not be applicable to some nursing programs in other states. To address these limitations, I adhered to all guidelines set forth by the Institutional Review Board (IRB) of record and the interview protocol guidelines to decrease perception of coercion, demonstrated respect, and maintained an objective stance during data collection.

Significance

The need to revisit and reform nursing curricula to meet contemporary practice standards is a national mandate and expectation across all schools and colleges of nursing and other health professions (Barton et al., 2009; Cabaniss et al., 2014; Cronenwett et al., 2007; Pauly-O'Neill & Cooper, 2013). According to the Health Resources and Services Administration (as cited in Cabaniss, 2014), nursing constitutes the largest of the health care professions' groups in the United States with well over 3 million people employed in diverse sectors of the healthcare system. The curricular change process is a daunting task and obtaining faculty input and support can be challenging (Hickey et al., 2010).

Obtaining faculty buy-in and participation plays a major role in curricula transformation and implementation (Hickey et al., 2010). Considering the directive to reform health professions' curricula and the challenges associated with the change process, my results from this study investigating faculty perspectives about the curricular reform process may facilitate open dialogue to address variables, gain insight into facilitating and inhibiting factors that impact on curricular change, and acquire new knowledge that may potentially inform future curricular development activities for stakeholders engaged in curricular reform.

A description of faculty perceptions during a curricular change process can provide invaluable data to facilitate and enhance the process in reforming curricula and streamlining better quality education for emerging nurse professionals. Open dialogue provides a sense of empowerment, encourages engagement, and develops a sense of belonging to improve current systems and promote reform in nursing education (Senge,

2012). The results of this study may also serve as foundational knowledge for future studies that advance the scholarship of quality and safety learning in nursing education.

Summary

The introduction of a QSEN initiative was subsequent to a call for reform in nursing and health professions education by the IOM (Didion et al., 2013; Disch, 2012). With the acceptance of QSEN competencies as part of the reform, the new challenge was to determine how nurse educators would incorporate and implement the competencies in nursing curricula (Hickey et al., 2010). In this interpretive, qualitative study, I examined faculty perspectives regarding the integration process using open-ended, semistructured interview questions to identify and formulate themes that informed the curricular revision and transformation process.

In the literature review in Chapter 2, I will assess the mandate for QSEN in bridging the education to practice gap and meeting the learning needs of emerging nurse professionals. Additionally, the methods and processes employed integrating quality and safety competencies into various nursing curricula will be examined with a focus on gaps in nursing curricula, faculty's role and attitudes regarding QSEN integration, and variables that impacted faculty's perception of readiness to teach and satisfaction with students' learning and performance. The review of the research that I discuss in the following chapter will highlight the importance of this study, demonstrate that prior studies have minimally explored faculty's perspectives about QSEN integration, and will serve as evidence to corroborate or oppose the study results and conclusions (see Maxwell, 2013).

Chapter 2: Literature Review

Introduction

A global mandate to reform education in the health professions in relation to how health professionals such as registered nurses are prepared for practice resulted in curricula changes across schools of nursing and other health related disciplines in the United States (Brady, 2011; Nielsen, Noone, Voss, & Mathews, 2013; Sherwood, 2011; Zeind et al., 2012). Salient factors and events influencing nursing curricula change and prelicensure nurse preparation for practice were the release of investigative reports issued by the IOM that revealed a precipitous decline in the quality of how healthcare was administered and delivered across the United States; the increasing presence and use of complex technology in healthcare settings; an expanding and diverse patient population; and a rising focus on cost containment, quality, and efficiency (Miller & LaFramboise, 2009; Ortiz, 2016; Spector et al., 2015; Thornlow & McGuinn, 2010). Additionally, the long-standing concern of nurse leaders regarding the gap between education and practice has served to fuel the impetus for curricula change in nursing education.

The introduction of a QSEN initiative, funded by the Robert Wood Johnson Foundation, sought to reform the nursing curriculum by using a competency approach to learning to increase knowledge and demonstration of higher performances in safety and quality practices and bridge the practice to education gap (Cronenwett et al., 2007; Disch, 2012; Sherwood & Drenkard, 2007). Although, historically, elements of quality and safety have been integral aspects of nursing education and practice, the extent of inclusion of quality and safety practices in nursing education has been limited or unclear

(Cabaniss, 2014). This innovative educational competency model introduced by the IOM and further defined, developed, and made appropriate for nursing by the QSEN faculty task force, included the competencies of patient-centered care, teamwork and collaboration, evidence-based care, safety, quality improvement, and informatics (Cronenwett et al., 2009; Sherwood, 2011). The goal of the QSEN competency model was to adopt a new and explicit approach to develop prelicensure nurses' levels of knowledge, attitudes, and performance skills in principles of quality improvement and safety and the six competencies to meet the demands of a changing healthcare landscape, the expectations of healthcare employers, and bridge the gap between classroom and practice (Jones, 2013; Sherwood, 2011; Sherwood & Zomorodi, 2014; Spector et al., 2015).

Nurses comprise the largest portion of the health care workforce, are intimately engaged in daily patient care activities, and their actions have direct implications on the outcomes of care (Bressan et al., 2016; Hickey et al., 2010). Historically, the methods of nurses' educational preparation and training for entry into practice have been diverse ranging from diploma, associate's, and baccalaureate degree programs (Wolff, Pesut, & Regan, 2010). Nurses' levels of knowledge and quality of preparation for practice have been influenced by nurse educators since educators assume a salient role in designing and implementing pedagogies and clinical practicum experiences for developing the knowledge, skills, and behaviors needed for safe and competent practice (Ginsburg, Tregunno, & Norton, 2013; Schaar, Titzer, & Beckham, 2015; Vaismoradi, Bondas, Jasper, & Turunen, 2014). However, despite the endorsement of QSEN integration into

the nursing curriculum by leaders in academia, such as the AACN and the NLN, research has revealed that the QSEN integration process has been associated with gaps in relation to the experiences of faculty integrating and implementing QSEN into the nursing curriculum, and understanding faculty perspectives concerning the integration process has been limited (Cabaniss, 2014; Ginsburg et al., 2013; Zeind et al., 2012; Zelenikova, Beach, Ren, Wolff, & Sherwood, 2014).

The purpose of this study was to obtain and investigate faculty perspectives integrating QSEN competencies as a curricular framework at two private nursing colleges in the Northeast United States. In this literature review chapter, I will provide an overview regarding the mandate for nursing curricular reform; analyze gaps associated with the QSEN integration process; and examine diverse methods and approaches to curricular design and integration, including factors that impacted faculty and the integration process. In this review, I will also address the theoretical underpinnings of the influence of systems on health care education and practice, including the developmental process associated with skill development. Finally, the chapter will end with a review of the literature concerning faculty member perspectives on the integration of quality and safety education.

Literature Search Strategy

My literature search strategy included accessing multidisciplinary databases within Walden University associated with research within the disciplines of nursing, health, and education. The databases I searched were Science Direct, ProQuest Central, ERIC, and Academic Search Complete. Other data sources were Medline and PubMed

and the primary search engine I employed was Google Scholar. Additional sources I searched included annotated bibliographies at the QSEN Institute web site (qsen.org) and peer-reviewed journals. My searches in all databases employed key words and phrases, including *quality and safety education for nurses, integrating quality and safety, nursing education and curriculum, faculty perception, faculty perspectives integrating QSEN into curricula, QSEN competencies, QSEN integration models, QSEN and IOM translation in practice, QSEN curriculum, and teaching strategies*. Finally, I used a Google alert for recently published literature in areas of quality and safety education that I could apply to enrich the quality of this research study. Only scholarly, peer-reviewed journals were used for this review of the literature. While the search strategy included integration of QSEN in various curricula, greater evidence regarding faculty input and perspectives about the structure and process of the integration process was needed to enhance the curricular integration process.

Conceptual Framework

The foundation of a systems thinking approach to understanding faculty perspectives and attitudes within educational systems is based on the systems principle of the interconnections and interdependency of subsystems and individuals and how their dynamic relationships influence outcomes and behaviors (Senge, 2006). Major factors that influence day-to-day realities in organizations are the result of the nature and outcomes of how systemic structures function as well as the influence of ingrained assumptions of individuals that direct internal processes (Senge, 2006). Structural patterns, such as policies, procedures, standards, communication practices, curricular

frameworks, and faculty professional development, provide a basis for how such patterns influence decision making by faculty and leaders within an institution (Senge, 2006; Thornlow & McGuinn, 2010).

Senge (2006), Bandura (1977), and Richardson (1996) acknowledged the influence of the external and internal environmental variables on behavioral responses. The concept of hidden curriculum within systems demonstrated how subtle and embedded cultural patterns of behaviors relate to power imbalances and incivility in the clinical learning environment (Kegan, 1994). Kegan (1994) described hidden curriculum as implicit laws, principles, and expectations of a culture or community. These implicit and explicit rules and expectations significantly influence values, perceptions, attitudes, and behaviors (Kegan, 1994). Bandura associated the adaptation of behaviors with the influence of role models in the environment regardless of their values for high or low standards of performance, while Richardson posited that teachers' attitudes and beliefs are salient concepts that influence their thought processes and perspectives, their classroom practices, and how they adapt to change.

Regarding learning and systems relations, Dewey (1997) and Senge (2006, 2012) posited an interconnection and interdependence between systems, such as societal and educational systems; their respective reciprocal influences; and the role they play in preparing learners for the workplace. Senge (2012) described that expansion and growth in academic institutions are the result of freedom and ability of teachers and leaders to engage in dialogue, reflection, and inquiry concerning challenging issues, since personal perceptions and perspectives are often hidden and untapped. Group discussion provides a

forum for safe discussion and helps to transform collective thoughts by drawing on each member's intellect to realign diverse perspectives toward a common goal (Senge, 2012). Within the larger context of systems, higher educational institutions are interconnected to the larger community, and learning and behaviors are influenced by vicarious and reciprocal activities between community leaders and school board officials (Dewey, 1997). In support of the relationship between systems of education and the community, Dewey posited an experiential learning model that focuses on the demonstration of skills as a preferred method of learning to successfully prepare and integrate learners into society.

The systems thinking perspective also espoused the influence of the external and internal environment of systems on behaviors and behavioral responses (Oshry as cited in Phillips et al., 2016). The concept of the hidden curriculum within systems demonstrates how subtle and embedded cultural patterns of behaviors relate to power imbalances and incivility in the learning and teaching environment (Tregunno, Ginsburg, Clark, & Norton, 2014). In addition to the influence of cultural silos on behaviors, both Kegan (1994) and Senge (2006) described the influence of mental consciousness on attitudes. Kegan proposed principles of progressive stages of consciousness development as directly related to cognitive development and social-interpersonal skills and alluded to inappropriate behaviors and conflict as a deficit in a person's cognitive and affective organizing ability to meet demands and expectations within the complex professional environment. Senge posited mental models as ingrained assumptions and lens through which the world and reality are interpreted and perceived. Systems are often shaped and

influenced by the perspectives and opinions of those who interact within them (Senge et al., 2012). What people believe shapes their perceptions, behaviors, and subsequent actions (Senge, 2006). Understanding what and how system structures and mental models influence, and shape perspectives provided me with a framework to interpret and understand faculty perspectives regarding the process of integrating QSEN competencies into nursing education.

Review of Literature Related to the Research Problem

The imperative to integrate and implement patient safety content into the nursing curriculum to enhance students' knowledge, performance, and attitudes in principles of quality and safety across health-related disciplines has been widely supported and emphasized in seminal studies by Cronenwett et al. (2007) and Sherwood and Drenkard (2007) and recent research studies by Ginsburg et al. (2013) and Mansour et al. (2015). Integrating quality and safety competencies into the nursing curriculum has been considered a factor to transform nursing curricula to better reflect the realities of the clinical setting and enhance prelicensure nurses' preparation for practice (Hickey et al., 2010; Sherwood & Drenkard, 2007). The introduction of a competency model to learn and demonstrate quality and safety knowledge, skills, and attitudes was considered a learning approach to reform nursing and health professions' curriculum and a foundation and evaluation method for nursing programs, including serving as a framework for standards pertaining to licensure, certification examinations, and accreditation (Brown, 2010; Cronenwett et al., 2007; Disch, 2012; Dolansky et al., 2013; Morris & Hancock, 2013).

Leaders in the healthcare field, such as the IOM, the State Board of Nursing, AACN, and the NLN, have also called for new learning experiences to reshape and empower emerging health care professionals to become adept at employing scientific evidence and technology; demonstrate competence in principles of quality and safety, including the ability to identify gaps in care; and implement innovative care strategies as a reprieve to a failing healthcare system (Cronenwett et al., 2007; Disch, 2012). Faculty are at the helm of the curricular reform process and faculty engagement and their level of competency directly impact nursing students' learning outcomes and their future practice. Faculty buy-in and engagement are also critical to curricula development of the QSEN competencies and understanding what social and environmental elements influence faculty perspectives is essential for success in the curricular reform process (Cronenwett et al., 2007; Sherwood & Drenkard, 2007; Zelenikova et al., 2014).

In this literature review section, a key factor that I will discuss is the mandate for curricular reform. Understanding what factors have influenced the mandate to incorporate quality and safety competencies into health professionals' curriculum, such as the nursing curriculum, provides a context to better understand the significance and purpose of this research study. Additional key factors I will address in this literature review are gaps in the QSEN integration process that were related to inadequate safety knowledge and skills, curricula gaps, teaching and learning gaps including faculty perspectives about QSEN integration, and diverse approaches to the QSEN integration process. These key factors will shed light on the challenges, barriers, and facilitating factors associated with systems related elements that influence the successful integration and implementation of

QSEN competencies into the curriculum, including teaching and learning outcomes in nursing education.

Mandate and Gaps in Curricular Reform

Several factors within nursing education have been identified by researchers within the healthcare disciplines that explain gaps in the curricular reform process and that impact the integration and implementation of QSEN in nursing curricula. Gaps that I discuss relate to nurses' and faculty members' levels of knowledge and skill in quality and safety concepts and principles, curricula gaps, as well as teaching and learning gaps, faculty members' challenges associated with curricular reform, and their attitudes toward QSEN integration. In addition, I also discuss approaches employed to integrate QSEN into nursing curricula.

Gaps in safety knowledge. The nursing curriculum is the learning platform where nurse learners develop foundational skills for their professional development. Researchers, however, have revealed that nurses generally lack the knowledge, skills, and explicit language associated with quality and safety concepts and reported nurses' general dissatisfaction with their education about error identification and management (Sherwood, 2011; Vaismoradi et al., 2014). In addition, the reeducation of safety science and concepts among health care professionals was also cited as a strategic means to mitigate errors in health care systems and bridge the gap to high quality performance (Cabaniss, 2014; Morris & Hancock, 2013).

Iranian nursing students' perspectives and feedback were obtained by Vaismoradi et al. (2014) regarding the content of a new nursing curriculum that focused on safety

concepts. Using semistructured questions in three focus groups, the research questions addressed nursing students' expectations of the new curriculum that would prepare them to meet standards for safe practice, and methods employed in the nursing curriculum that would prepare them to demonstrate safe practice. Vaismoradi et al. found that the salient themes that emerged from the study pertained to deficiencies in relation to how the curriculum was structured to learn safety knowledge and the organization of clinical practicum experiences. Vaismoradi et al. noted that students expressed a desire for inclusion of safety knowledge that included learning human error concepts into the curriculum and having focused clinical practicum experiences that facilitated skill development in error identification and prevention.

Medication errors are associated with safety attitudes and skills, and nurses' knowledge about pharmacology and training in high alert medications were the focus of two studies conducted by Lo, Yu, Chen, Wang, and Tang (2013) and Hsaio et al. (2009). Lo et al. utilized questionnaires in a cross-sectional study to obtain the perspectives of 199 practicing Taiwanese nurses' and 136 faculty regarding their knowledge and skills in pharmacology and in high-alert medication administration before a teaching intervention. The purpose of the study was to understand practicing nurses' and faculty's views about their training in high alert medications, the importance of these medications, how frequently nurses were taught, and the ideal time for teaching. High alert medications are drugs that pose a significant risk that can cause serious harm if used in error. Lo et al. found that although both practicing nurses and faculty generally viewed pharmacology knowledge as important for medication administration, however, Taiwanese nurses

perceived that less time was spent on pharmacology and learning high alert medications in nursing education compared to faculty. Lo et al. discussed that both college and hospital training were essential for competency development, and that lack of course structure and adequate time spent on teaching pharmacology resulted in insufficient knowledge, was a potential source of stress and anxiety, and a potential factor that led to medication errors.

Additional studies that investigated the source of medication errors related to nurses' level of knowledge and skill regarding high alert medications were conducted by Hsaio et al. (2009). This study developed and validated a measurement tool to assess nurses' knowledge of high alert medications and analyzed nurses' reports of medication error incidents. A true-false questionnaire was provided to evaluate participants' knowledge of high alert medications and a second part of the study analyzed medication errors reported by participants. Study participants comprised of 385 Taiwanese nurses who worked in general hospitals and had the opportunity to administer high-alert medications. The study found that half of the participants had correct responses to true-false questionnaires that evaluated drug administration and drug regulation, while approximately less than one third considered themselves to have sufficient knowledge about high-alert medications. Additionally, more than three fourths reported lack of pharmacology related knowledge as a main barrier to medication safety and expressed a desire for more training. Regarding medication incidents, of the 184 administration-related errors that were identified, approximately one third were related to wrong drug and wrong dose. Finally, medication administration errors that resulted in life threatening

injuries were found in 8 out of 9 cases that involved high-alert medications administered by the intravenous route (p. 1, 12). Based on this study's findings, Hsaio et al. suggested that increasing nurses' knowledge and developing standardized drug regulatory procedures as one method to minimize errors associated with administering high-alert medications. In addition to nurses, however, knowledge gaps in quality and safety concepts and principles were also identified among faculty in nursing education.

Gaps in faculty knowledge. Faculty is a salient contributor in knowledge construction and application, and faculty's knowledge and skills are needed to successfully develop and implement the curriculum (Farley et al., 2013). Research, however, revealed that faculty did not understand fundamental QSEN competency concepts (Morris & Hancock, 2013; Sherwood, 2011); had low technological literacy skills (Found, 2012); had difficulty identifying appropriate pedagogies (Thornlow & McGuinn, 2010); and developing learning objectives. Consistent with past research during the initial roll-out of QSEN, recent studies also found that faculty's knowledge and proficiency regarding QSEN competencies remain elusive and inadequate (Barnsteiner et al., 2013; Bryer, 2014, Pollard et al., 2014).

Cabaniss (2014) studied the relationship between faculty's knowledge and degree of QSEN integration and teaching across the curriculum. Web surveys were utilized to assess degree of implementation of two QSEN competencies related to safety and teamwork and collaboration into the nursing curriculum of 18 Alabama community college associate degree nursing schools. The purpose of the study was to determine the number of hours dedicated to classroom and clinical experiences of the two competencies

of safety and teamwork, to determine faculty's perception of the "attitude" aspect of the two competencies, and any prior engagement in QSEN training. Study participants were full-time faculty with a minimum of 3 years in teaching. Cabaniss found that of 28 faculty members, 23 admitted to never participating in any QSEN development program, while five acknowledged to having attended a development program. Cabaniss also found that half of the respondents reported that they had knowledge of the competencies, while half reported having minimal to little or no knowledge, with two of the faculty respondents reporting that they had not heard of the QSEN competencies. Regarding the process of integration, Cabaniss found that safety and teamwork occurred early in the nursing curriculum (program) and were emphasized to a greater degree in the clinical setting compared to the classroom setting. Conclusions from the study found that the competencies were not well integrated suggestive of possible gaps in faculty knowledge with implications for successful integration throughout the curriculum including classroom and clinical practicum.

Additional research regarding the impact of faculty training on teaching and curricular integration was conducted by Hung, Huang, Tsai, and Chang (2015) who investigated qualification and resources for faculty, curriculum design, course evaluation, and barriers to teaching EBP. The instruments utilized were questionnaires and participants were faculty members from 21 undergraduate nursing schools and colleges in Taiwan. Results found that among the 18 schools that responded, approximately half of faculty received EBP certification from an international or local institution, while a second half had a minimum of 4 hours of EBP training; in addition, one third of those

who taught EBP had not received any training. Regarding resources, only one third of schools had adopted or developed standardized teaching materials, and teaching challenges were associated with lack of comprehensive faculty training, limited learning opportunities to engage students in applying EBP concepts at the bedside, coupled with lack of adequate time and course materials for teaching. Results of this study seem to suggest that decreased faculty training, resources, and time influenced QSEN's content and teaching in the curriculum, and lack of faculty training may have potentially influenced the overall design and effectiveness of the curricula change process as well as student learning outcomes.

In addition to decreased teaching, lack of faculty knowledge in QSEN has led to inconsistencies regarding the inclusion of some QSEN competencies and the absence of others from the curriculum and thus impacted on students' learning outcomes. Studies such as Morris and Hancock's (2013) cited that inconsistent inclusion of informatics and interdisciplinary teamwork in the curriculum were related to faculty reports of needing clarity regarding some competencies' definitions, and initial study findings from Cronenwett et al. (2007) during the early phase of the QSEN initiative found that when faculty were exposed to the QSEN competency definitions, they realized that they did not have the expertise needed to effectively teach all six competencies and lacked skills in areas of EBP, quality improvement, and systems knowledge.

Additional corroborating evidence reported in the Zeind et al.'s (2012) study was related to the inconsistent inclusion of some competencies in the curriculum due to faculty's lack of knowledge in those competencies such as informatics and quality

improvement. The study utilized web-based surveys of curriculum committee members and department chairs from 91 pharmacy schools to determine the extent of integration of IOM competencies including how the competencies were integrated into their Pharm D curriculum. The study reported inconsistencies and low rates of inclusion of some IOM competencies in the curriculum, such that EBP and patient-centered care were more widely implemented compared to informatics (36%), teamwork (34%), and quality improvement (29%), despite a strong desire by faculty (93%) to implement all IOM competencies into the curriculum. Finally, in Pollard et al.'s (2014) study, in addition to having lower levels of integration in the curriculum, faculty reported being least satisfied with student competency achievement in areas of informatics and quality improvement. Lack of faculty expertise in QSEN especially in areas of informatics and quality improvement impacted the integration of these competencies into the curriculum. In addition, those competencies were taught less, and faculty were not satisfied with student achievement despite being willing to incorporate and teach those competencies.

Curricular gaps. Corroborating studies have found curricular gaps regarding the inclusion of patient safety knowledge in health professions' curricula. In a World Health Organization sponsored study, Farley et al. (2013) conducted an evaluation study of their patient safety curriculum guide assessing for quality of content, relevance, and learning effectiveness and found typical students' responses were "no one has ever taught them like that before, no one had ever mentioned that things can go wrong, what to do when things go wrong, and how are you going to manage it if things go wrong" (p. 33), thus confirming not only curricular gaps in safety teaching and learning, but that safety

knowledge had enhanced students' confidence and preparedness to handle errors in practice. In a similar study, Mansour et al. (2015) evaluated the effect of teaching two safety competency topics published by the Multi-Professional Patient Safety Curriculum Guide. The study addressed nursing students' attitudes toward safety, level of knowledge about safety concepts, and students' perception of the teaching method employed. Study results found that students reported high levels of satisfaction learning safety concepts, demonstrated positive attitudes about patient safety, however, expressed that patient safety topics be introduced earlier in the curriculum. Tregunno et al. (2014) in their qualitative study on integrating patient safety into health professions' curricula discussed that within the decade of the release of the IOM's 1999 safety report, reviews of medical schools' curricula that taught patient safety concepts were sparse or missing, with one medical school reporting less than 10 contact hours of training. Conclusions from these studies noted that lack of knowledge about safety concepts in curricula negatively impacted new health professionals' confidence whereas increased knowledge of safety concepts resulted in positive change in students' attitudes regarding patient safety principles.

The outcomes of learning safety knowledge impacted students' attitudes toward safety principles, enhanced their confidence in safety performance, and the quality of their learning experiences. However, additional curricular gaps requiring reform were related to lack of knowledge about systems, the knowledge and influence of culture, workload, and the socialization process in the clinical work environment. Dolansky et al. (2013) and Farley et al. (2013) posited the importance of systems knowledge in nursing

curricula and noted that human and systems components such as mental assumptions, communication, and culture provided a holistic perspective of analyzing errors and how they influence human behaviors.

Inadequate knowledge about systems were found to impact both students' learning experiences in academia and at onset of practice since most student nurses were not familiar with the realities of professional practice and often feel unprepared (Valdez, 2008). Both Dolansky (2013) and Miller and LaFramboise (2009) reported positive student learning outcomes after receiving instruction about systems, the latter reporting that students whose learning included a combination of didactics, clinical practicum, and engaging in practical safety projects demonstrated a holistic approach in problem solving with a greater awareness of the impact of communication on patient care outcomes and processes. Additionally, Duclos-Miller's (2011) findings concerning stress in a graduate nurse transition study of 46 new nurse graduates were primarily related to lack of understanding of systems related factors such as employer expectation, understanding of roles and responsibilities, and the socialization process. In addition, poor classroom to practice transition experiences were noted to increase the incidence of errors among novice nurses early in practice (Vaismoradi et al., 2014).

Teaching and learning gaps. A basic sequential and development approach to teaching and learning has been a common approach in nursing education; however, the three-tier elements (knowledge, skills, attitudes) of each QSEN competency including knowledge of systems has been complex and challenging for faculty to determine course content, and course alignment for knowledge, clinical experiences, and evaluation.

Educators play a salient role in curricula development and need skills to design and map their curriculum to determine the what, when, and how of curricular content to promote progressive and successful learning. Faculty's level of expertise in QSEN is essential for curriculum development and in bridging teaching and learning gaps.

A web-based Delphi survey of nurses' leaders and educators (Barton et al., 2009) examined 162 elements of each of six QSEN competencies to determine placement in the curriculum (table 4, p. 321). Foundational QSEN elements (knowledge, skills, and attitudes) of the six competencies were recommended for the "introduction" beginning phase while other advanced skill and knowledge elements of teamwork and collaboration, EBP, informatics, and quality improvement were recommended for placement at the intermediate and advanced level. Differences in participants' responses regarding placement of the QSEN elements suggested complexity of the QSEN curriculum and potential challenges for QSEN teaching related to development of content and objectives appropriate to program level.

Limited learning experiences and quality of QSEN content were posited as factors that could impact QSEN teaching and learning (D'Eramo & Puckett, 2014; Ginsburg et al., 2013; Sullivan et al., 2009). Appropriate curricula content in quality improvement for senior nursing students in relation to the expectation of employers at start of practice was the basis for D'Eramo and Puckett's (2014) concern who argued whether it was realistic for senior nursing students to perform quality improvement skills such as data analyses, conducting tests for improvement projects, and measuring change results. D'Eramo and Puckett noted that new nurses did not have adequate learning experiences in

improvement methodology and faculty lacked the expertise needed to teach the quality improvement (QI) competency. D'Eramo and Puckett posited a developmental approach to learning quality improvement from understanding the influence of regulatory requirements to an advanced stage where students can verbalize the importance of measuring data, understand the role of benchmark standards, and participate in project-improvement activities. Learning outcomes and student satisfaction associated with curricula content were also noted in Sullivan et al.'s (2009) mixed method study that utilized a four-point Likert-type scale to measure students' perception of exposure to QSEN competency instruction and their attitudes regarding the importance of QSEN skills. Sullivan et al. found that compared to higher ratings attributed to topics that addressed strategies for risk reduction, communicating care between transitions (handoffs) and assessment of pain and suffering, topics related to quality improvement and evidence-based practice competencies that addressed cause and effect diagrams, evaluation of practice changes, and use of evidence-based reports received the lowest ratings. Study results suggest possible learning gaps associated with the methods or timing of students' instruction in relation to their level of knowledge and clinical experience.

Additional ineffective learning opportunities at clinical learning institutions were also found to create a learning gap for acquiring requisite quality and safety skills for students of nursing. Ginsburg et al.'s (2013) cross-sectional study that assessed patient safety competence among newly graduated licensed physicians, registered nurses, and pharmacists focused on socio-cultural aspects of patient safety associated with culture,

team spirit, communication, risk management, and human factors. The survey instrument measured perception of competence and confidence in patient safety concepts and compared differences in confidence levels between classroom-only instruction and clinical practicum experiences among the three professional groups. Study results found that although nurses scored generally higher in levels of confidence across all safety dimensions, nurses reported significantly lower confidence when learning occurred in clinical settings in specific areas of teamwork, communication, and safe culture compared to physicians and pharmacy graduates who reported significantly higher levels of confidence subsequent to their clinical learning experiences. Study conclusions regarding the learning gap in nurses' learning were attributed to power imbalances between physicians and nurses and incivility in the workplace. Kim et al. (2015), however, who utilized surveys to measure nursing students' confidence, competence in QSEN knowledge and skills, and socialization skills after participating in an RN residency program, found that students reported an overall improvement in competence and confidence at the end of their residency program with an increase in scores at the end of their program compared to preprogram scores. It is important to note that the students' nurse residency training was provided through a collaboration of state funded universities and clinical centers. Study results also suggested that student nurses' perception of their competency skills could have been influenced by the type and quality of their training program as well as the clinical placement site. It might also be that collaborative efforts between universities and clinical partnerships could have resulted in greater focus and

learning opportunities in patient safety compared to generic nursing programs that are not affiliated with medical centers.

Gaps in safety skills. Safety performance is an inherent value within the discipline of nursing and clear communication has been identified as a key component of safety skill and competency (Sherwood & Zomorodi, 2014). Lack of communication skills, however, was recognized as a common theme that challenged new nurses' degree of confidence by Ortiz (2016) and Pfaff, Baxter, Jack, and Ploeg (2014) both of whom examined the phenomenon of confidence among newly graduated registered nurses during their first year of practice. New graduates associated poor communication skills with not knowing how to respond to physicians about patient care issues, disgruntled patients, or responding to condescending remarks from preceptors and peers. Communication is an essential element in safety practice and staff communication was cited as one of several goals in the 2016 Hospital National Patient Safety Goals (Joint Commission, 2016). Earlier survey findings conducted by the Nursing Executive Center (Berkow, Virkstis, Stewart, & Conway, 2008) were consistent with recent research results of Ortiz and Pfaff et al. regarding communication gaps among new nurse graduates. According to Berkow et al. among 5,700 front-line clinical nurse leaders and educators, less than one third were satisfied with new graduates' competency in how they communicated with physicians. Pfaff et al. (2014) also found that communication was reported by new graduates as a challenge in their quest to confidently engage in interprofessional collaboration. To illustrate learning gaps in communication skills in some medical schools, (Pronovost and Vohr, as cited in the Interprofessional

Collaborative Expert Panel, 2011) reported that heavy emphasis was placed on certain technical skills compared to the absence of time spent on learning and acquiring essential communication and teamwork skills required for daily practice (p. 22).

Weak communication skills are not only evident among nursing students but among nursing faculty as well. Zelenikova et al. (2014) studied faculty perception of their own competence in EBP skills from 50 top graduate nursing schools in the United States and found that among 14 aspects of the evidence-based competency, “communicating best evidence to peers, social groups, the media, policymakers, and mentees” had the second lowest score (5.84) on a scale of 2–7 (Table 5, p. 409). In addition, Zelenikova et al. discussed that faculty perceived and acknowledged a lack in communication skills to execute evidenced-based principles in the clinical setting, demonstrate strong leadership and mentorship for students, and influence change.

In addition to communication skills, newly graduated nurses identified documentation skills as a critical skill that was not adequately taught (Ortiz, 2016). Contrasting this finding, Casey et al.’s (2011) mixed methods study comprised of senior nursing students found that few students reported difficulty in documentation skills. Incongruent differences in documentation skill responses between senior student nurses (Casey et al., 2011) and newly graduated nurses (Ortiz, 2016), however, reveal and confirm the gap that exists between classroom knowledge and skill versus the realities and experiences of the workplace.

Knowledge of human factors is an element of systems knowledge and has been described as the interrelation between humans, the tools and equipment they use, and the

environment. Human factors play a role and impact performance in areas of technology and the handling of medical devices (Farley et al., 2013). Knowledge of human related factors such as fatigue or reliance on memory provide a context in which to better understand why and how errors might occur in the clinical work setting. Examining human factors was posited in Cronenwett et al.'s (2007) seminal work as a necessary competency to minimize risks and harm to patients. Human factors also encompass skill and knowledge level, heavy workloads, and interruptions, including physical and environmental limitations that may potentially contribute to errors. Although the interrelations between human factors and workload was proposed to impact patient care quality in Holden et al.'s (2011) cross-sectional study, recent research regarding the teaching and learning of human factors in nursing curricula remain limited and lacking.

Faculty Challenges in Curricular Reform

Faculty members play a salient and multifaceted role in implementing curricular reform (LeCuyer, DeSocio, Brody, & Schlick, 2009; Pohl et al., 2009), have a vested interest, and are generally committed to nursing students' preparation for practice (Vaismoradi et al., 2014). Challenging factors related to workload, resource availability, support and professional development were identified during curricula reform. The nursing faculty workforce has been confronted by a myriad of factors such as a diminished and aging workforce, reports of dissatisfaction with intention to leave because of heavy workloads, and challenges with recruiting and retaining new faculty (Beckham, 2015; Ellis, 2013; Nardi & Gyurko, 2013).

Cabaniss (2014) noted that nursing faculty's workload is primarily comprised of courses that included two 8-hour days of clinical training, participation in college committees, and faculty meetings. Workload and lack of faculty availability were cited by Brady (2011) as a limiting factor impacting curricular implementation, whereas, to the contrary, increased faculty and resources were recommended for successful QSEN integration (Disch et al., 2013). Ellis (2013) noted that while the role of university faculty has been diverse and complex, workload equity has been a concern for faculty with implications impacting on adequate time to interact with students and to develop and implement teaching materials. Zelenikova et al. (2014) also found that in addition to large class sizes, there was limited class time for students to learn appropriate skills for EBP coupled with faculty's lack of expertise in evidence-based competency.

The roles and responsibilities of faculty include curricular re-design activities such as curricular assessment, development and evaluation of pedagogic strategies and evaluation tools (Armstrong et al., 2009; Joyner, 2016; LeCuyer et al., 2009; Pohl et al., 2009; Sullivan et al., 2009). Both Cronenwett et al. (2009) and Pollard et al. (2014) found that the process of learning and redesigning a new curriculum was daunting for faculty, with the central question of not knowing what, when, or where concepts should be placed in the curriculum, and with many expressing concerns regarding their level of preparedness to teach and mentor students in patient safety. Corroborating evidence in Hickey et al. (2010) cited challenges that were associated with lack of experience in curriculum redesign among newer faculty, obtaining consensus regarding course content, and determining how to incorporate QSEN competencies into a dense curriculum.

In addition to curricular design challenges, lack of knowledge and expertise in the quality and safety competencies posed an additional challenge given heavy workloads that required faculty to learn new scientific knowledge, as well as to find, develop, and implement new pedagogical strategies, clinical objectives, and methods to evaluate learning in classroom, clinical practicum, and simulation activities (Cronenwett et al., 2007; Vaismoradi et al., 2014). These challenging factors were further corroborated in Bryer and Peterson-Graziose's (2014) survey of 17 nursing faculty before and after a QSEN faculty development workshop to determine the extent of QSEN integration into their curriculum. Survey results revealed that prior to the workshop, faculty did not understand how to clearly define and evaluate the competencies, and experienced challenges as they developed and devised course objectives and specific assignments, and as they employed learning strategies and clinical practicum activities for each of the six competencies. However, self-reported surveys after a series of monthly workshops found that faculty verbalized better understanding of the QSEN competencies and that a larger number of faculty had integrated, implemented, and increased QSEN content into the curriculum.

Organizational factors related to leadership support and resource availability for faculty training and teaching were found in studies by Stichler, Fields, Kim, and Brown (2011) and Zelenikova et al. (2014) to be associated with faculty challenges encountered during curricular change. Zelenikova et al. attributed positive perception of EBP effectiveness with access to resources such as different databases and the overall vision and mission of the organization. In Disch et al.'s (2013) examination of the extent of

QSEN among six schools, the researchers concluded that two major factors associated with QSEN implementation were leadership stability and support and access to resources. Disch et al. found that when faculty were asked what factors contributed to their program's success, they attributed success to strong and engaging leadership, access to resources, support, and opportunity for professional development. Additional faculty challenges included fear of having to meet the demands that accompany curricula change (Joyner, 2016), increased enrollments, growing competition for clinical placement sites (Tregunno et al., 2014), and increased concern for stronger clinical partnerships for adequate skill development (Disch et al., 2013).

Clinical practice partners are a great resource to learn and develop quality and safety competencies (Sherwood & Drenkard, 2007). Through academic and practice collaboration, students can engage in patient safety educational and concrete experiences to develop their knowledge, skills, and professional attitudes particularly in QSEN's competencies. Workplace variables, however, associated with the learning culture at clinical institutions, limited learning opportunities, and clinical partnerships have impacted the reform and implementation process.

An Interprofessional Education Collaborative initiative led by the Institute of Healthcare Improvement to integrate QSEN content and clinical practicum experiences into curricula was investigated by Headrick et al. (2012). Despite students' interest in learning, the study reported that finding meaningful learning experiences in quality improvement at most clinical sites were challenging, and learning was limited to specific topics and observations based on the needs of the clinical site thus limiting students'

experiential learning experiences for higher cognitive and social skill development. Additionally, to understand the impact of learning experiences on student nurses' behaviors regarding safety principles, Miller and LaFramboise (2009) studied the impact of learning about safety in the clinical practice (hospital) setting versus classroom lectures using a mixed method, quasi-experimental approach. Three learning groups were created that consisted of a control group that received no safety instruction, an experimental group that utilized classroom lecture, and a second experimental group that combined classroom lecture regarding safety, clinical practicum, and a clinical project to learn safety and quality concepts. Miller and LaFramboise reported a subsequent increase in students' problem-solving attitudes among only those students who participated in the second experimental group that utilized classroom, clinical practicum, and a safety project. Study conclusions posited that effective learning and behavioral change may require both didactics with clinical practicum skills. Similar findings were found in Jones (2013) who employed a pretest, posttest study design to evaluate first-semester nursing students' learning of safety concepts. Pretesting occurred during the first and second week of 4 weeks of didactics, followed by a posttest after the completion of 7 weeks of clinical practicum in an associate's nursing degree program in east Texas. "Inevitability in making errors" attitudes were assessed before and after project implementation, and students were noted to have a change in belief that errors in health care were not inevitable and a change in safety attitudes that they described as "not tolerating uncertainty in patient care" (p. 144).

Although clinical partnerships are needed to facilitate the integration of safety knowledge with clinical experience for competency development, Tregunno et al.'s (2014) qualitative study that investigated Canadian medical, nursing, and pharmacy faculty perspectives on socio-political factors in the learning environment cited “challenges in preparing safe practitioners,” and “culture of the practice setting” (p. 259) as two out of seven salient themes that emerged in their integration study. Nursing faculty who were interviewed spoke of differences between the safety culture in classroom and in clinical settings that did not support learning, and cited incivility as a factor undermining learning and confidence among nursing students. Tregunno et al. also discussed the impact of culture on the teaching and preparation of emerging health professionals and cited disrespectful treatment, destructive power imbalances, and learner incivility as outcomes of tacit and hidden assumptions in the clinical learning environment.

The challenges of curricula reform are reflected in the complex relationships between the organization, faculty members and the curriculum, and clinical learning sites. Some challenging factors identified in the research were faculty's lack of expertise to competently teach the QSEN competencies, cultural barriers at some clinical sites, and restrictive institutional policies that inhibit and limit positive learning experiences. In addition, paucity of clinical sites, decreased time to teach and learn QSEN, and lack of resources for adequate learning for moderate to large student groups were cited as inhibiting factors to skill development (Headrick et al., 2012; Sullivan, 2010). Faculty has a salient role in curricula change and understanding faculty's attitudes provides

insight regarding how they perceive QSEN and the nuances of the curricula reform process.

Faculty Attitudes in Curricular Reform

Positive faculty attitudes, beliefs, and engagement influence curricular reform and learning outcomes and gaining faculty buy-in was recommended as essential to enhance QSEN integration initiatives (Disch et al., 2013). Corroborating evidence showed that faculty generally felt positive about the QSEN curriculum and integrating QSEN into the nursing program curriculum and had high expectations regarding student learning outcomes (Pollard et al., 2014; Zeind et al., 2012; Zelenikova et al., 2014). Study results however, revealed that although faculty were motivated to integrate QSEN, faculty felt unprepared to model the competencies (Zelenikova et al., 2014) and expressed strong interest in their professional development. Some factors that raised concerns regarding QSEN pertained to managing curriculum change and the complexity of the redesign process (Cronenwett et al., 2009) and that time was needed to learn new curricula content in a crowded curriculum (Burke, as cited in Stichler et al., 2011). Organizational factors were noted in Hickey et al. (2010) and Stichler et al. (2011) to influence faculty attitudes in areas related to workload and time pressures, internal group dynamics such as relationships, achieving consensus, faculty empowerment, and degree of administrative support. In addition, Joyner (2016) noted that faculty attitudes were influenced by how they perceived curricular change activities, for example, as an opportunity to assess faculty performance versus a sincere re-assessment of the curriculum itself, fear of losing

control over what and how courses are taught, and negative experiences from prior experiences with curricular change.

Approaches to QSEN Integration

Despite positive faculty attitudes regarding the QSEN curriculum, the process of learning and integrating QSEN competencies into an established curriculum were found to be challenging. In addition, diverse strategies have been employed to reform the nursing curriculum. In this section, I discuss strategies used to reform the curriculum and challenges that occurred during the reform process.

An analysis of comparing, contrasting, and aligning QSEN knowledge objectives with the core competencies of a generic nurse practitioner (NP) and doctoral nurse practitioner (DNP) curriculum (cross-mapping) was conducted to assess for and integrate QSEN content into the curriculum (Pohl et al., 2009). The purpose of the cross-mapping process was to determine congruence between the QSEN knowledge objectives and the core competencies of a nurse practitioner and DNP curriculum. Challenges that occurred in the integration process were associated with lack of congruence between curricula objectives and the task to critically analyze, create, and realign broader, more generalized objectives of the NP and DNP curriculum to specific cognitive-based descriptive objectives of the QSEN curriculum. Study results indicated that although some similarity existed between QSEN, the NP and DNP competencies, the QSEN approach differed for some competencies, and DNP and NP objectives did not identify specific cognitive skills for competency achievement.

A similar method of comparison and analysis was employed to integrate QSEN into a curriculum (Armstrong et al., 2009). The QSEN competencies were adapted as an overarching frame for a competency-based outcome performance assessment (COPA) curriculum model to create a modified QSEN-COBRA curricular framework. Eight of the core COPA competencies of assessment and intervention, communication, critical thinking, human caring relationships, teaching, management, leadership, and knowledge integration skills were reasoned to be core operational modes for QSEN implementation. Challenges associated with the integration process pertained to faculty buy-in, initial resistance to change, identifying and threading QSEN content across courses, and for developing clinical evaluation tools. QSEN integration was thought to enhance the COPA curriculum model by developing students' knowledge base of systems concepts and the explicit role of nurses in navigating and influencing systems processes. Additionally, a remodeling of pedagogical structure was employed by both Brady (2011) and Piscotty et al. (2010) to integrate QSEN competencies into classroom and simulation learning using diverse strategies such as on-line, didactics, videos, reflective discussions, practicum experiences, and a student-directed simulated project. Challenges reported by Brady during the restructuring process related to lack of human resources such as faculty and the need for greater collaboration for successful course development and implementation.

A constructivist and reflective approach to learning and applying advanced level QSEN competencies during an on-line post-master's quality and patient safety course in a DNP nursing program was introduced as an innovative pedagogical approach to integrate QSEN competencies (Manning & Frisby, 2011). Students constructed their learning by

following instructor guidelines to create safety content in an educational video production on hand hygiene (safety topic) over a 15-week period. Evaluation methods were based on faculty and peer review regarding QSEN knowledge and competency skills in areas of evidence-based care, and skills of teamwork and collaboration, and informational technology. Despite the successful outcomes and high levels of student satisfaction, challenges associated with QSEN integration were the substantial time required by faculty to plan, develop, and execute the diverse course techniques and objectives for effective learning.

Finally, the QSEN competencies were adopted as a framework in clinical practice for new nurses' orientation and training at the start of practice (Fater, Weatherford, Ready, Finn, & Tangney, 2014). The QSEN competencies were added to four competencies of systems-based practice, professionalism, leadership, and communication in an innovative "Nurse of the Future Nursing Core Competencies" curriculum developed for new nurses by the Massachusetts Department of Higher Education and nursing colleges. Study findings were that obtaining an adequate number of trained mentors and preceptors to guide, develop, and evaluate new nurses' knowledge and skill in quality and safety competencies was challenging.

Summary and Conclusions

The drive for curricular reform to better prepare emerging nurse professionals for practice emerged out of alarming statistics of human and institutional preventable errors that resulted in numerous deaths (Sherwood & Zomorodi, 2014). The introduction of QSEN competencies served to address gaps in areas of patient-centered care, EBP,

teamwork and collaboration, safety, quality improvement, and informatics. Faculty play a prominent and diverse role in the structure, process, and implementation of curricular reform and students' learning and performance are influenced by faculty, their interests, knowledge, skills, and attitudes toward curricular program development. Curricular gaps revealed that lack of adequate QSEN content, instructional and practicum strategies were deficient in the nursing curriculum. Gaps in faculty knowledge revealed that inadequate knowledge and skills in QSEN competencies impacted their ability to effectively develop teaching strategies, objectives, and evaluation methods. Challenges found in teaching institutions ranged from negative cultures for learning and limited time and targeted opportunities for skill development; in addition, internal factors within educational systems were related to quality of leadership and the support they provide to faculty, access and availability of resources for professional development, and time needed to learn and teach new quality and safety concepts for successful learning outcomes.

The need for ongoing organizational support is imperative to sustain curricular change activities and to successfully reform the curriculum. Additional research that examines academic organizational support in relation to degree of QSEN integration in the curriculum is warranted, including the need to explore the use and effectiveness of a standardized QSEN curriculum, and to assess QSEN competency achievement among new nurse graduates at the onset of practice. By exploring and understanding faculty perspectives about the curricular integration process I found similar gaps that validated the findings found in the literature review.

In Chapter 3, I discuss the design and methodology regarding faculty perspectives about QSEN integration, how they perceived their role in curricular change, and their overall attitudes regarding the QSEN learning model. I explain the study population and instrumentation including the method I used for data analysis. Finally, I describe strategic measures I used to ensure trustworthiness and ethical standards throughout the data collection and analysis process.

Chapter 3: Research Method

Introduction

The purpose of this basic qualitative interpretive study was to understand the perspectives of faculty as they integrated QSEN competencies into a nursing program curriculum at two schools of nursing at two private colleges in the Northeast United States. In this chapter, I will describe the processes that were implemented to obtain data, analyze findings, and formulate conclusions regarding faculty perspectives and attitudes toward the QSEN integration process. In addition to the methodology, I will describe measures I implemented to establish credibility, dependability, and maintain ethical standards.

Research Design and Rationale

In this qualitative interpretive study, I explored the experiences, attitudes, and perspectives of faculty members during the integration of six quality and safety competencies in their nursing curriculum as part of a curricular reform process to improve prelicensure nurses' clinical performance and knowledge in quality and safety competencies (see Patton, 2002, 2015). The research question for this study was: What are faculty members' perspectives regarding integrating quality and safety education for nurses (QSEN) competencies as a curricular framework for a nursing program curriculum? Additional subquestions were: What are faculty members' attitudes toward curricular change? and How do faculty members perceive their role in curricular change?

Qualitative research as a method of inquiry has historically been associated with exploring, understanding, and interpreting meanings and perspectives of individuals or

groups to a phenomenon or problem (Creswell, 2014). Qualitative research has also been used as a platform to empower individuals to share their stories, perspectives, and voices to better provide insight into participants' settings and experiences (Creswell, 2014). Qualitative analysis includes interpreting interviewee responses to determine what is meaningful and to identify recurring patterns and themes (see Patton, 2015).

The central concept that I focused on in this study was examining and understanding faculty perspectives and attitudes regarding QSEN integration and curricular reform at each of two nursing colleges in the Northeast United States. I chose a basic qualitative interpretive approach within a systems context for this research (see Patton, 2002). This interpretive stance provided me with an effective method with which to interpret the direct quotes, attitudes, and views obtained from participant interviews to subsequently develop and formulate patterns and themes creating new knowledge to inform the integration process (see Patton, 2002, 2015).

I originally considered using a phenomenological approach; however, this approach focuses on how lived experiences of individuals influence and shape their beliefs, sense of reality, and external behaviors (see Creswell, 2009; Patton, 2002). The assumption of "essence" in phenomenology refers to a phenomenon commonly experienced and shared by other human beings (e.g., motherhood, or adolescent fathers as fathers); (Creswell, 2013, p.137; Patton, 2002, p. 106). As stated in Merriam (2009), "a phenomenological approach is well suited to studying affective, emotional, and often intense human experiences" (p. 126). Patton (2002) also distinguished the difference between interview questions that elicit an analytical, interpretive, or opinion statement

versus a response that describes the affective, emotional, or feeling aspect of an experience (p. 350). The purpose of this study was not aimed at understanding, describing, and analyzing how faculty formulate meaning, interpret, or make sense of the integration process, nor did I assume their primary experience was affective or intense. I chose a basic qualitative interpretive design because my research interest was to obtain unique intellectual and personal perspectives regarding a curriculum change that could potentially provide knowledge that can inform future integration processes (see Patton, 2015). Additionally, the feedback that participants provided regarding the QSEN integration process was interpreted through the lens of a systems and professional developmental perspective and not through the personal lens of individual participants for emerging themes and patterns.

Initially, I also considered a case study design; the use of a case study approach, however, involves an in-depth description and analysis of a bounded system, item, or entity that employs multiple sources of information for data collection (see Creswell, 2013; Merriam, 2009). Additionally, the researcher in a case study seeks to identify salient variables in relation to how they interact with each other (Merriam, 2009). Although case studies may employ the use of interviews, in this study I did not investigate or obtain knowledge about the QSEN integration process in a bounded setting but elicited faculty views and perspectives about QSEN and the curricular change process; therefore, a case study design was not a suitable approach.

Role of the Researcher

I was the sole researcher for this study, and I recruited all participants; developed the interview questions; observed, recorded, and transcribed all interviews; and completed all data analysis. I worked for 1 year as a new full-time faculty instructor and, at the time of the study, worked as a part-time instructor at one of the two colleges of nursing where I collected data. At the time of my hire, the full-time faculty at that school of nursing were already in the process of integrating QSEN into the nursing curriculum.

Upon employment as a new member of the full-time faculty, I also participated in the process of weekly staff meetings. Being a part of the process and having familiarity with the integration process, it is possible that I may have been biased toward the QSEN curriculum. During the interviews, I was cognizant that possible gaps or incomplete responses could occur based on participants' assumptions regarding my knowledge and experience about the integration process.

To minimize such bias, I asked additional probing questions to clarify incomplete responses to produce richer and informative data. During the interviews, I was careful to maintain a neutral, nonjudgmental stance; interact with the participants with honesty and respect; and, prior to the start of each interview, explain that there are no right or wrong answers to questions and that each person's perspectives were highly regarded and respected and would not negatively impact on any aspect of our working relationship. Additionally, none of the participants reported to me or were supervised by me neither did I conduct any evaluation, such as a peer evaluation, at any time. I emphasized that the

purpose of the interview was to gather data only, and I was careful not to change, endorse, or discredit any person's views (see Patton, 2002).

To minimize bias, the interview questions were examined by my dissertation committee. During the data collection and analysis, I also used a journal to reflect on observations and participants' responses to promote a neutral stance and enhance accuracy during the analysis and interpretation of the data. Participants were informed of their right to refuse to answer questions that they perceived as causing discomfort, clarify any questions that they did not comprehend, and that they had the option to withdraw from the study at any time. I also explained that all ideas, views, or perspectives were confidential and noted the benefit of obtaining faculty perspectives was to gain better knowledge and understanding concerning QSEN integration to inform future curricular reform processes. Regarding ethical issues, I had no personal vested interest in pursuing this study nor was there any conflict of interest because of this study. I ensured that privacy was maintained for all data I collected and used for this research to meet dissertation and doctoral requirements.

Methodology

This methodology section will include a description of the setting, sample selection and size, instrumentation, data collection, and analysis. I will also discuss the study design and rationale for the selected approach, including the strategy I employed for ensuring trustworthiness and validity. In this section, I will also include strategies I employed to establish trustworthiness including measures to decrease bias and maintain ethical standards.

Setting and Participant Selection Logic

I recruited study participants from the nursing education department of two private nursing colleges in the Northeast United States, one of which I was employed at on a part-time basis at the time of this study. I chose the site where I was employed because of the unique collaborative method employed to integrate QSEN competencies into the curriculum and chose the second site based on the recommendation of my workplace's community IRB to increase the pool of eligible participants. This purposeful sample was comprised of nine nursing faculty members who worked at these two private colleges and participated in integrating QSEN into their nursing program curriculum. These participants were chosen because of their experiences with the QSEN integration process, leading to their ability to provide rich data about the curricular change process to identify patterns and emerging themes (see Patton, 2002).

To minimize coercion, the first step that I employed was to inform the dean and vice president of academic affairs at the college where I worked and the dean at the second college about my interest in obtaining faculty perspectives regarding QSEN integration process. I submitted an overview of the purpose and methodology of the study and a provided a few examples of the interview questions to each of the two community partners' IRB committees for review. After obtaining approval for the proposal from my dissertation committee, I applied for IRB approval from Walden University because the community IRB where I worked declined to be the IRB of record. Once I obtained IRB approval from Walden University and the two community partners, I requested access to each of the community partners' internal e-mail to send the initial invitation and to

distribute the invitation in person to nursing faculty members who participated in the QSEN integration process at their respective schools of nursing. I also requested permission from the two community partners' IRBs to use their campuses for interviews and to use external electronic devices to contact and communicate to all potential participants. I sent a reminder e-mail using the community partner's e-mail system containing the same content out to all participants 5 to 7 days after the initial invitation.

Subsequent to receiving IRB approval from the community partner's institution and Walden University, for those participants who responded to my invitation in person or by e-mail, I scheduled an interview date, time, and venue that was convenient for each participant. In advance of the interview, I e-mailed the interviewees an interview protocol and a consent form. The consent form met the ethical standards of Walden University (IRB Approval Number 08-21-17-0071754) and each community partner and was used to obtain permission from each participant prior to the start of each initial interview. Participants were encouraged through e-mail to review the written resources and interview questions prior to the interview. All participants acknowledged that they had reviewed the documents and waited to sign the consent form in person on the day of the interview. Each interview was conducted face-to-face in a private setting either on or off the college campus. I used a digital recorder to record the interviews with the participant's consent. I transcribed the interview data for each of the nine participants and saved the data in a private, locked file on my personal computer. At the completion of this dissertation the electronic file will be stored in an iCloud file for 5 years to maintain confidentiality.

Because I worked for 1 year as a full-time faculty member at one of the nursing colleges, this placed me at an advantage to better interpret the behaviors, language, meanings, and nuanced responses that arose during the interviews because of my familiarity with the culture and the contextual environment (see Patton, 2002). I actively worked at being cognizant of my own personal bias that might have influenced participants' responses because of my familiarity with them. I maintained a neutral, nonjudgmental stance to minimize incomplete participant responses based on perceptions that I may have the expert knowledge and experience about the subject matter or for fear of reprisal. Additionally, at the start of each interview, I was careful to clearly state the purpose of the study, explaining about the need for knowledge about the QSEN integration process and that data obtained from diverse perspectives was one way to gain new knowledge about the process. I also emphasized that there were no right or wrong answers and that all data were confidential and would be examined and analyzed from a neutral perspective. I purposely sought to establish an atmosphere of trust and respect and used vetted questions (see Merriam, 2009). Participants were instructed about their choice to refuse or postpone a response to any question at any point during the interview and that their perspectives had no bearing on any professional peer relations. In qualitative research, the size of a sample corresponds to what the researcher needs to know, what will be useful, what has credibility, and follows guidelines that focuses on extensive and saturated details about the processes that is studied (Patton, 2002, p. 244; Creswell, 2013). The in-depth interviews I conducted with nine nurse educators with follow-up additional probing questions about QSEN integration including data from my

journal notes were sufficient for data saturation to identify recurring themes, develop concepts, and identify recurring patterns to construct new information about the QSEN integration process.

Instrumentation

The data I obtained were from semistructured open-ended interviews that were digitally recorded and transcribed. I also used follow-up probing questions to clarify responses and to obtain deeper and richer knowledge about the research topic. In semistructured interviews the wording and sequencing of questions are predetermined and directed at a specific topic; however, other questions are flexible and can be modified to more accurately reflect the research question based on the type of participants' responses, and as new ideas emerge (Merriam, 2009). Use of this type of flexible instrument allowed me to explore much deeper and wider into the topic so that I could compare and distinguish between diverse responses. This also helped to diminish interviewer bias, facilitated increased focus about the subject matter, and contributed to the strength and effectiveness of my instrument tool (Patton, 2002).

The initial interview questions were based on review of the literature, were vetted by a committee member, and refined as the interviews progressed. The probing questions I, as the interviewer, employed were to ensure that I understood what the participant stated and allowed me to divulge into newly crafted questions that I did not anticipate prior to the interviews. During all interview questions, I avoided assumptions or leading questions that took a specific stance about the QSEN education module, or about the QSEN integration process (see Patton, 2002, p. 370).

Data Collection

All the interviews I conducted were held on a one-on-one basis and lasted for approximately 40 to 60 minutes. Prior to each interview, to clarify what information was desired and to allow time for personal reflection, I e-mailed the interview guide with the vetted interview questions and on the day of the interview, a hard copy was provided to the participants (see Patton, 2002). I conducted the interviews with minimal distractions in a private setting in a face-to-face meeting that was determined by the participant. I conducted a trial of the interview questions with a friend to assess for clarity of the questions asked, determine possible reactions or responses the questions may elicit, and to enhance my verbal and nonverbal communication skills (Patton, 2002).

I wrote personal notes on salient points, behaviors, preconceived expressed assumptions, and emotions expressed during the interview and during the review of the transcript. I made every effort to be cognizant of my personal beliefs and assumptions during the documentation process to maintain objectivity, show sincere interest in the participants' responses, and created an atmosphere of acceptance during each interview (Janesick, 2011). I respectfully asked all participants for their permission for one follow-up interview in the event I needed to ask additional questions for clarification, missing data, or to obtain greater in-depth information to improve the accuracy and richness of the data. I informed all participants that they will receive a copy of the transcript for review to ensure accuracy and that they were free to make any corrections to the document.

All participants agreed to face-to-face interviews and I recorded each interview on a digital recorder with the interviewee's permission. After each interview, I emailed a written transcript with initial coding of each interview to the interviewees for review and to obtain feedback for accuracy and to enhance validity. I observed and utilized a personal journal to document interviewees' expressions and non-verbal behaviors to enhance my understanding of participants' perspectives. The use of observation served as an additional source to corroborate findings about participants' perspectives because observation allows for inferences to be drawn about a perspective and helps to further confirm understanding and interpretation of participants' responses (see Maxwell, 2013). In addition, I compared participants' responses with the findings of the peer-reviewed literature to validate study findings and conclusions. Finally, the data I collected were stored on my personal computer in an iCloud file for confidentiality and will be maintained for 5 years.

Data Analysis Plan

Data analysis is the process of transforming raw data into study findings that can be communicated to stakeholders. In qualitative analysis, the rigor of the data is associated with the presence of the researcher, the quality of the interaction between the researcher and the participant, triangulation of the data, and interpretation of the data (Merriam, 2009). For this basic qualitative interpretative design, I was the primary instrument for data collection, analysis, interpretation, and development of summary findings. I employed the use of open coding with inductive analysis of in vivo data,

observed for patterns, and categorized similar chunks of data to construct and develop themes (see Patton, 2002).

After each interview, I transcribed the digitally recorded interview data into a Word document on a private computer and critically reflected on the transcript to capture the thoughts and views and made some additional notes that provided greater depth and breadth to answer the research question. To capture central ideas and my reflective thoughts, I always kept the purpose of the study in full focus as I prepared for each interview to maintain quality data (see Merriam, 2009). For each completed transcript, I utilized open coding with inductive analysis as my analytic method to identify, distinguish, and extrapolate salient ideas from the semistructured verbal interviews (see Patton, 2015). Open coding is a line by line approach that involves inductive analyzing, comparing, and contrasting portions of raw in vivo data (Merriam, 2009). Inductive analysis searches qualitative data for patterns and themes without preconceived analytical categories at the start of the analysis, and avoiding bias is an important part of this process (Patton, 2015).

For data analysis, I initially employed a first cycle of coding in which I assigned a code label that reflected main variables in the interview questions, for example, “faculty attitudes,” “faculty beliefs,” or a code label was extracted from a segment of data or datum (see Miles, Huberman, & Saldana, 2014). Codes can be a word, short phrase, or paragraph that captures the essence of language-based or visual data. Although codes can be verbatim quotes, they can be constructed by the researcher after careful and deep reflection of words spoken by participants from interviews, or from field notes, journals,

or documents (Miles et al., 2014). The method of code assignment was based on an “in vivo” and “values” approach where the code labels reflected the essence of participants’ verbatim words, their beliefs, attitudes, and perspectives (Miles et al., 2014). Attitude is the way a person thinks or feels about another person, or idea, while belief is part of a system that is associated with personal knowledge, opinions, prejudices, and perception of the world (Miles et al., 2014). A subcode “outlier” was used only for statements that did not reflect the responses of the overall group of participants.

After the initial cycle of coding, I created a second cycle of coding where I grouped distinct chunks of similar data into categories that reflected answers to the research questions. Once the categories were organized, I developed a common theme within the context of the research questions for each category. Miles et al. (2014) described this second cycle method (pattern coding) as “a way of grouping those summaries into a smaller number of categories, themes, or constructs” (p. 86). Maxwell (2013) also recommended organizing categories based on broad issues (topics) that I want to investigate, or substantive categories that identify and describe the content of a person’s statement or beliefs that may not fit organizational categories (pp. 107-108). I also analyzed my journal entries including analytic notes as secondary sources to corroborate and validate the emerging themes and codes (see Miles et al., 2014; Patton, 2002). Identifying emerging themes facilitates identification and development of constructs that can further explain faculty perspectives about the QSEN integration process (Merriam, 2009; Miles et al., 2014).

Trustworthiness and Reliability

Trustworthiness, credibility, and reliability are essential since they can impact study outcomes and ultimately the public at large. The notion of internal validity or credibility refers to determining whether the data collected accurately reflected the perspectives of the participants (Merriam, 2009). Appropriate strategies to establishing credibility in a study are using triangulation, described as using different sources, methods, and literature to authenticate the study findings (Creswell, 2013).

In this study, the primary source of data came from initial interviews with study participants who were engaged in the QSEN integration process at their school of nursing. During the interviews, I established a good rapport with the interviewees and asked for additional comments that were not a part of the semistructured interview protocol. The responses I obtained from in-depth interviews and probing questions further enhanced my understanding of participants' responses and provided rich data to identify recurring themes and patterns. To enhance credibility, I requested respondents' review and feedback of the interview transcript with the initial coding (Creswell, 2013, p. 252). I kept a research journal as a reflective tool for analysis of salient gestures and emotions that I observed during the interviews and created additional notes during the review of the transcript. In addition, findings from the literature review were utilized to further corroborate the study findings and conclusion. Regarding the interview questions I created, an external check of the interview questions was vetted by a committee member and by a personal peer who had no vested interest in this study. During data analysis, I kept the purpose of the study in full view to ensure that all analyses were

conducted within the context of the research. Additionally, I investigated discrepant cases to facilitate objectivity, decrease presuppositions, or any personal bias that might have impacted the study findings (see Merriam, 2009).

Regarding reliability of data, I obtained a second coder for purposes of comparing findings to enhance credibility and to better assess any personal biases toward the research findings that might be present. I also explained my rationale for codes selection during the development of constructs and critically assessed whether the data correlated with the study findings and conclusions. In relation to transferability, the purposeful sample of full-time nurse faculty members who were engaged in the QSEN integration process for data collection provided rich descriptive data that can be applied in similar settings for future research within the field of nursing education (Creswell, 2013).

Credible research relates to the nature of the rigor of the research and the personal and philosophical attitude of the researcher toward qualitative research (Patton, 2002). As the researcher for this study, I was very cognizant of my beliefs and assumptions regarding the quality and safety curriculum, of the possibility of bias responses during an interview versus obtaining data from an anonymous survey. I conducted this research with the highest regard of respect for others and maintained neutrality during the interview process. The interview guide (Appendix B) indicated the purpose of the study, the confidentiality of all responses, and stipulated that answers to questions were neither right or wrong. I employed an objective approach versus asking leading questions (Patton, 2002, p. 369). This approach was one way to enlarge the scope of a question and

decrease the incidence of biased responses. A member validating process was in place to verify the accuracy of the transcript. Prior to obtaining data from voluntary participants, I obtained IRB approval from the two community partners including the IRB at Walden University.

Summary

This basic qualitative interpretive study explored faculty perspectives concerning integrating quality and safety competencies into a nursing curriculum. I utilized open coding to obtain and analyze data from semistructured interviews and employed additional sources to confirm accuracy of data such as, reflective notes about the interviews and during data analysis, compared participants' responses at the two research sites for similarities and differences, and compared my study findings and conclusions with the findings in the peer reviewed literature. All aspects of the study were conducted in an ethical manner and I utilized measures to increase validity and decrease bias during data collection and analysis. In Chapter 4, I will discuss how I conducted an in-depth analysis of all participants' responses and will report the results of the study.

Chapter 4: Results

Introduction

Since the introduction of the QSEN initiative to enhance the learning of nursing students in standards of higher quality and safety over a decade ago, the perspectives of nursing faculty who have integrated QSEN into the curriculum have not been extensively explored. The purpose of this qualitative interpretive design study was to investigate the unique perspectives of nursing faculty members as they integrated QSEN competencies into the nursing curriculum. The research question for this study was: What are faculty members' perspectives regarding integrating quality and safety education for nurses (QSEN) competencies as a curricular framework for a nursing program curriculum? Additional subquestions were: What are faculty members' attitudes toward curricular change? and How do faculty members perceive their role in curricular change? Both Senge's (2006) core concepts regarding the influence of systems variables and Benner's (2001) stages of professional development served as a frame through which I analyzed and interpreted discrepant data or findings in this study. In this chapter, I will describe the participants' setting and demographics; the process of data collection; and the method of data analysis with evidence of trustworthiness, including the study results which were my analyses of participants' responses.

Setting

I obtained data for this study from nursing faculty at two colleges in the Northeast United States. Three participants were recruited from one campus that has a traditional 4-year baccalaureate nursing undergraduate and graduate program, and six participants

were enlisted from the campus of a private college with a progressive nursing program track that consists of a practical nurse certificate, an associate in applied science degree, and a bachelor's degree in nursing.

One of the colleges had experienced a change in the dean of nursing at the onset of the QSEN integration process, while the second college experienced change in the dean of nursing position on two occasions; the first change occurred at the onset of the integration process, and the second occurred during the QSEN integration process. At one campus, one participant commented on the leadership change in relation to her autonomy as an instructor and curriculum change. She commented:

Supposedly, [the] dean...says the faculty owns the curriculum. That's who is supposed to be who's making the changes,...it hasn't been like that in the last couple of years; she's only been the acting dean since XXXX, so it was difficult to get through; [so], certain things were highly suggestive that we do, you're going to do this, you're going to do that, and you didn't really have a chance to say if you wanted to do it, or didn't want to do it.

During the time that I conducted the interviews, however, I observed that Harriet from the progressive nursing program provided only positive responses concerning the entire integration process, and Bertha from the traditional 4-year baccalaureate nursing undergraduate and graduate program changed her initial response to a question when asked to elaborate. Because data collection started during the summer months, it created a minor challenge since potential participants were away from the college campuses. Also,

it was during the summer break that a second new acting dean replaced a former dean at one of the private nursing colleges.

The first interviews for this study occurred during the month of August; one in the private home of one participant and the second in a quiet area of a public park. The remaining seven interviews occurred during the months of the fall semester, and each interview was conducted in either a quiet laboratory or office setting on a college campus except for one interview that was conducted in a large but quiet campus lecture room due to limited space at the college campus. I set and agreed upon the date, time, and venue for each interview with each participant. This collaborative decision facilitated a physical and psychological setting conducive to open dialogue. Prior to the start of each interview, in addition to reviewing the consent form, I expressed my appreciation for and value of the participant's time and emphasized the uniqueness of his or her perspectives and that there were no right or wrong answers. Emphasizing that there were no right, or wrong answers seemed to put each participant at ease to freely express his or her perspectives and promoted a strong rapport with the participant. To help evoke participants' perspectives, I maintained good eye contact and a posture of acceptance and interest in participants' viewpoints throughout the duration of the interview (see Janesick, 2011).

Demographics

As indicated in Chapter 3, I initially recruited participants from the nursing education department at a private college within the Northeast United States where I taught on a part-time basis at the time of the study. Study participants were purposefully selected and were full-time nursing faculty members who were engaged or participated in

integrating quality QSEN competencies into curriculum related activities, such as curriculum change meetings, lectures, clinical practicum training, simulation, or in students' evaluations. At the request of the first community's IRB where I taught on a part-time basis, I recruited a second community partner to obtain the required number of participants for this study and to increase privacy by obtaining data from different sources. I subsequently recruited three additional participants with similar backgrounds at a second private nursing college in the Northeast United States.

All nine participants held at a minimum a master's degree, either in a health-related discipline, nursing, education, or a nurse practitioner's degree, and one participant held a doctoral degree. Additionally, 6 of the 9 participants were actively enrolled in a doctoral program, and 8 out of 9 participants were women. All nine participants were full-time faculty members who taught both didactics and clinical practicum, and their teaching experiences ranged from 2 to 12 years in nursing education. Two faculty members reported that they had prior experience as clinical educators during their years of employment in the clinical setting. Six of the 9 participants were known to me from the site where I was employed as a part-time instructor at the time of the study and where I also participated in some QSEN integration meetings at the start of my employment when I worked as a full-time faculty member. I knew no one at the second institution where I collected data.

Data Collection

The method of data collection I employed in this basic qualitative interpretive study was face-to-face interviews of nine participants who were full-time nurse faculty

members and who had participated in integrating QSEN into their nursing program curriculum that included didactics, simulation, clinical practicum, and evaluation. Before the start of data collection, I created and assigned pseudonyms for each of the nine interviewees to ensure their confidentiality. Hillary, Shelly, Rhoda, Lorna, Saul, and Harriet worked at the first campus that has a progressive nursing program track that consists of a PN certificate, an associate in applied science degree, and a bachelor's degree in nursing, and Bertha, Anna, and Paula worked at the second campus that has a traditional 4-year baccalaureate nursing undergraduate and graduate program. At both campuses, each participant assumed the roles of classroom and clinical practicum instructor and were full-time employees. At the first campus, all six participants' teaching experiences ranged from 4 to 12 years, 5 out of 6 participants had enrolled in a doctoral degree program, and one participant held a doctoral degree. At the second campus, the teaching experiences of the three participants ranged from 2 to 9 years, and one participant held a doctoral degree and two held master's degrees.

As outlined in Chapter 3, after I obtained IRB approval from Walden University and the community institutions, I conducted each interview at a date, time, and location either on or off the campus that was convenient for both the participant and me. Each interview was held at a private, quiet area that facilitated a focused and intimate conversation where the participants seemed to have felt unrestrained to express their perspectives about the QSEN integration process. Prior to each interview, I provided the participant with a copy of the interview protocol and consent, in the event the participant wished to review the questions and sign the consent prior to the interview. Immediately

before each interview, I reviewed the consent and the purpose of the study and emphasized confidentiality and that there were no right or wrong answers. The interviews lasted approximately 40 to 60 minutes, and I used probing questions and repeated my understanding of some participants' responses to ensure that the data collected reflected what was intended. Additionally, I used probing questions to allow for deeper, richer, and wider perspectives. I was careful to maintain a nonjudgmental, neutral, and accepting stance throughout each interview and encouraged participants to provide additional data they deemed important that was not a part of the interview protocol. I observed at times that some participants' expressions and responses were intended to demonstrate that they were competent in their teaching of QSEN and that some participants provided positive responses on all aspects of the integration process. All interviews were recorded using a digital recorder, and I manually transcribed all data from the digital recorder into a word processing program at a private location.

Data Analysis

My initial step in the data analysis process was reading, reviewing, and highlighting important statements in the interview transcripts that pertained to the research questions (see Maxwell, 2013). During the interviews I observed participants' gestures, attitudes, and reactions to different questions to enhance my understanding and analysis of their responses. After the interviews, I critically reflected on participants' verbal responses to capture the essence of their perspectives, being cognizant of any personal bias to obtain data that are credible (see Merriam, 2009). I corroborated my findings from my observation notes and created additional memos during the

transcription of the data to clarify and enhance my understanding of participants' responses. I also kept the purpose of the study, the research question, and subquestions in full view to identify emerging themes that addressed the purpose of the study and the research questions (see Patton, 2015).

I then employed an inductive data analysis strategy as described by Miles et al. (2014), using open, line-by-line in vivo coding of verbatim words of participants that reflected their beliefs, attitudes, and perspectives (value-based type of coding) and grouped phrases and sentences with common meanings to arrive at themes that emerged from the data. Grouping chunks of data with similar meanings facilitated deeper reflection and analysis to provide answers to the research questions (Miles, 2014). I also wrote brief notes regarding salient gestures, emphases, and emotions that I observed on which to reflect during my analytic review of the interview transcripts to provide additional insight regarding any implicit or explicit factors that might have influenced participants' perspectives about the QSEN integration process. I also read and reviewed the transcripts several times. The data obtained from all nine participants at the two college campuses were analyzed together because most responses were similar and the sample sizes for each site would not have been sufficient to draw conclusions. Appendix C provides examples of how quotations were grouped to formulate and develop the main themes for each research question.

I chose to present the themes in relationship to the research question and subquestions. The themes that emerged to the central research question were: QSEN integration is complex and QSEN integration is a process. The themes that emerged

regarding the two subquestions were: QSEN is similar to nursing, QSEN fills the gap in the nursing curriculum, QSEN posits a broader approach to learning, and faculty are at the helm of curricular reform. Within the first main theme of QSEN integration is complex, subthemes emerged regarding faculty preparation, translating QSEN, implementing QSEN, faculty's knowledge, and limited experiential learning opportunities that helped to further explain the nature of the complexity of the integration process. Participants' responses described challenges, questions, and experiences as they integrated QSEN and spoke of their perspectives regarding QSEN in relation to the standard curriculum and expectations in current practice.

All participants were full-time nursing faculty with various years of teaching experience in higher education and who had participated in the QSEN integration process. One participant, Bertha, emphasized competence in QSEN and spoke of her teaching QSEN experience as being "very natural," "second nature because it's something that I'm used to," without "difficulties" or "any impediments along the way." Although admitting to challenges associated with revising the curriculum, Harriet reported that the transition to the integrated curriculum was "pretty smooth" due to having a "curriculum committee." These responses did not reflect the general responses provided by the remainder of the participant group who reported on the complexity of QSEN integration and implementation and faculty's need for increased knowledge about QSEN. For example, Hillary described the QSEN integration process as "arduous," while Lorna spoke of levelling the QSEN objectives with program level as "very hard," and Rhoda explained that "the most challenging thing" was her "understanding [QSEN] and

getting that knowledge.” One possible explanation for the discrepancy regarding over-emphasizing competence in QSEN could have been related to Bertha’s recent change in career to become a new faculty member and admitted to having worked in a culture where: “for fear of not seeming informed, or as though we are experts in our practice, we shy away from asking for help.” A possible explanation for the second participant’s perception of the smooth curricular transition was related to the participant’s decreased involvement in the implementation and teaching of QSEN, as she indicated that she did not teach core courses.

Evidence of Trustworthiness

To ensure credibility and trustworthiness, I adhered to the research standards as set forth by the IRB at Walden University and my committee as described in Chapter 3. I was careful to follow all ethical standards of confidentiality, privacy, obtaining consent and avoiding coercion. Other methods I employed to enhance trustworthiness were triangulation and transcript review strategies.

Credibility

As outlined in Chapter 3, to establish data credibility, my research questions were vetted such that all potential responses would adequately address and answer the research question. All nine participants who were interviewed were full-time nursing faculty members who worked at two nursing colleges and participated in QSEN integration in their nursing program curriculum. The use of semistructured and probing questions allowed for accurate, in-depth, and rich data to identify recurring patterns and themes to answer the research questions (Patton, 2002). To validate the quality of the data, I

requested participants' feedback of the typed transcript and initial coding. During data analysis, I utilized reflective notes of the face-to-face interviews and the interview transcript, compared participants' responses at the two nursing colleges for corroborating or contradicting evidence, and corroborated the findings of the peer-reviewed literature to further authenticate the study findings and conclusions (Creswell, 2013). Additionally, I asked my dissertation chair to examine the initial coding and utilized feedback to maintain neutrality and minimize personal bias when interpreting the results.

Transferability

By adhering to the participant selection criteria for this study that was comprised of full time nursing faculty who participated in QSEN integration, coupled by a qualitative interpretive design, allowed for authentic data that can be applied to similar settings such as nursing colleges that are embarking on QSEN integration. The results obtained from this study may provide baseline knowledge that can potentially enhance future QSEN curricular change activities.

Confirmability

During the data analysis and interpretation, I engaged in reflexive analysis and carefully examined how participants' responses might have been influenced by explicit and implicit factors such as nuances in the immediate work environment, participants' concerns regarding their own responses and how it would be perceived by the interviewer, and participants' personal perception of QSEN and curriculum reform. I connected the codes, and themes to the research purpose and question as well as the conceptual framework. In addition, I compared participants' responses at the two

research sites for corroborating evidence and compared the study findings and conclusions with the findings in the peer reviewed literature.

Results

Study participants were recruited from two nursing colleges in the Northeast United States and all nine participants from the two campuses were full time nursing faculty members who were engaged in QSEN integration in didactics, simulation, and clinical practicum teaching. Five out of six participants who were recruited from the more progressive nursing program were female with teaching experience ranging from 4 to 12 years, and three participants recruited from the more traditional baccalaureate and graduate nursing program varied in teaching experience from 2 to 9 years. The decision to integrate QSEN into the curriculum at the two colleges was influenced by accrediting agencies, such as the Commission on Collegiate Nursing Education and the dean of the each of the two colleges initiated the QSEN integration process.

For the progressive nursing program, the primary method employed to integrate QSEN into the curriculum was weekly faculty staff meetings compared to structured meetings held by a curriculum committee comprised of faculty members at the second college with the traditional baccalaureate and graduate program. The latter program also implemented a “train-the-trainer” initiative that incorporated staff who volunteered to learn QSEN to work one-on-one with faculty during the early phase of QSEN integration. The progressive nursing program, however, utilized general resources such an initial workshop and access to a faculty training website to facilitate the integration process at the early onset. Among both campuses, new faculty members had limited to no

experience with curriculum change compared to participants with greater than 3 years of experience. Additionally, at both campuses, participants expressed that curriculum management was an integral part of their role and responsibility and felt that they should assume a salient role regarding decision-making at the onset of curriculum change. Participants from both campuses also reported similar responses regarding their perception of the standard curriculum, QSEN, and the challenges they experienced during the QSEN integration and implementation process.

I have organized the findings of this study by the central research question and sub-questions after employing an interpretive strategy to arrive at meanings and common themes as they emerged during the data analysis. The central research question for this study was, what are faculty members' perspectives integrating quality and safety education for nurses (QSEN) as a curricular framework for a nursing program curriculum? The two subquestions were, what are faculty members' attitudes concerning curricular change? and how do faculty members perceive their role in curricular change? In describing the study results, I begin with the first sub-question regarding faculty members' attitudes about curricular change because first understanding faculty's attitudes about curricular change helped me later to analyze the context and reasoning behind faculty perspectives of the integration process and how they perceived their role in the curricula change process.

Subquestion 1: Faculty Members' Stance Towards New QSEN Competencies

I identified three themes about new QSEN competencies, all of which reflected faculty's overall positive stance toward this new educational model. They were: QSEN is

similar to nursing, QSEN fills the gap in the nursing curriculum, and QSEN posits a broader approach to learning. All three themes reflected participants' positive attitudes regarding QSEN. For example, eight out of nine faculty members expressed positive feelings concerning the QSEN curriculum change because participants believed that QSEN's focus reflected issues central to the profession of nursing, nursing education, and students' learning and performance. For example, Rhoda emphasized: "I found it [QSEN] to be needed. I found it to be good because safety is the key, quality is the key." In a similar statement, Rhoda referred to the concept of quality as a "great idea" because it was associated with having "positive patient outcomes," and a third participant, Lorna, spoke passionately regarding safety performance among nurses:

I think it was common sense, I think quality and safety have been always promoted when I worked as a bedside nurse and...I think in the educational setting... you must teach quality and safety because it's an expectation...If you're a nurse, if this is not your priority as a nurse, then I mean -- what's the point?

In the following section, I discuss study participants' perspectives regarding QSEN's close alignment with nursing, how QSEN addressed gaps found in the curriculum, and how QSEN expanded the scope of knowledge and learning.

QSEN is similar to nursing. All nine participants viewed QSEN competencies such as patient-centered care, teamwork and collaboration, and safety as foundational elements in nursing education and practice and that these elements were previously taught in the nursing curriculum. I asked participants how extensively they integrated

QSEN into the courses they taught, and whether QSEN content impacted the content and quality of their teaching. Harriet responded,

I don't like the word 'impact' because we've always taught safety, we've always taught sticking to evidence-based practice, but I think what QSEN does is to make you more aware...but it is not that we were not teaching it, but we are more aware.

Shelly provided a similar response,

I think of a lot of the things we were doing already, even though we weren't explicitly talking about QSEN or addressing QSEN competency... A lot of the things I think about was included in the course already...specifically safety, specifically patient-centered care, because we are a culturally based curriculum.

Paula, Anna, and Rhoda noted that patient-centered care had been a part of the curriculum, and, as explained by Rhoda, patient-centered care was easier than other aspects of QSEN because it was, "something we've been able to really do a lot, and speak to a lot, more so than the other parts." Anna spoke of patient-centered care as "what maternity nursing is," and commented that she would usually teach about "ethical issues," and "being nonjudgmental." Paula explained, "we've been teaching it all these years saying that the patient is the center of the care...but at the same time, it was not labelled QSEN – but we've been teaching this for many years." Both Bertha and Hillary's comments regarding QSEN as a process to provide care provided insight into participants' overarching perception of QSEN. From my analysis of the data, I deduced that participants generally felt that the fundamental elements found in the QSEN

competencies were similar to principles inherent in nursing practice and nursing education; also, these perspectives served as a basis for framing participants' positive attitudes as they embarked upon curriculum change. Despite QSEN's nursing-based concepts, participants also acknowledged that in relation to the realities of current practice, the standard nursing curriculum was lacking in structure and content to adequately prepare students for the contemporary practice setting.

QSEN fills the gaps in the nursing curriculum. All study participants interviewed supported QSEN content due to their perceptions of curricular gaps related to deficiencies in the curriculum framework, objectives, and content. Two participants, Shelly and Hillary, commented that the nursing curriculum had lacked structure and needed a "framework," to enhance both its structure and content and become competitive. Shelly described her initial reaction to QSEN as,

OK, this is great, we will have a framework to build our curriculum upon, so, I just thought that, I knew that many schools were going in that direction... we really did not have a framework for the curriculum. The objectives were pretty much just standard objectives... I thought, it was a good idea to have a framework.

Hillary spoke about the importance of objectives and felt that although the curriculum revisions were "the hardest part," she saw a "major improvement" that "had a lot to do" with the new framework. When Hillary was asked whether she felt that QSEN integration resulted in a stronger curricular structure, she responded:

Yeah, having a framework is very good, it helps you to form the objectives and all of them are critical to nursing...but in most hospitals today, every patient is really at risk...instead of just feeling, well, all these patients are going to get pressure ulcers if they're a diabetic or in the ICU when they're hooked up to a ventilator...it's nice to feel that you can be doing things to either take care of it early, or prevent it altogether...and QSEN integrates all that and it gives people a method of looking at it –makes it all more real.

Hillary's response suggested that she thought QSEN's focus on prevention, safety, and quality facilitated a stronger curriculum frame for effective learning and higher skill performance.

Other participants commented on their course objectives after the start of QSEN integration. Lorna felt that after revising and creating new objectives based on the QSEN framework, both the simulation course objectives and students' evaluations were clearer, and the course content was easier to teach. When discussing differences between QSEN and the standard nursing curriculum, Lorna referred to the complexity and narrow scope of the standard curriculum she felt were too "difficult" to interpret and translate into the curriculum. She explained, "during earlier times as a nursing student, the curriculum was based on abstract "mega, abstract theories" that were challenging to "interpret," and to "conceptualize" into the curriculum; however, "with the QSEN...they're very straight forward." This "mega" theory as described by Lorna focused on the "individual" versus the overall "health care system," and objectives were narrower in scope and focused solely on what was being studied or what was "going on in a situation" such as a

particular “nursing intervention,” a “pathophysiology,” or a “pharmacology” course. In a similar response, Saul described his perception of the standard curriculum as, “the generic curriculum is just that – it is very generic - whatever is in the text book-type of curriculum, but when you’re talking about the QSEN competencies... it’s much more patient-centered, outcome centered.” One faculty, Harriet also cited a significant deficiency in the standard curriculum as failure to seamlessly integrate the “lectures” [theory] with the “clinical” [practicum] experience for optimum learning.

In addition to the need for curriculum restructuring, the content of the standard curriculum was thought to be outdated, while QSEN was thought by all interviewees to reflect current trends and practices in health care. Bertha alluded to this in the following statement,

I found that a lot of the information is relevant in real practice, in current practice...It definitely is a more practical approach and again it does marry a lot of what we do on the health care side of things... will be a helpful tool...once you get out there and work.

Lorna also commented: “I like the contemporary part of QSEN...it’s more up-to-date, it’s much more applicable to what’s going on now in the real world;” and Hillary spoke of new expectations of nurses:

...but now, evidenced-based practice is on your license, it’s expected that you’re going to be guided by the best evidence and take care of your patient. And I always tell my students, look at what written on the license because it says you’re supposed to do that and the patients and families are expecting that. So, even

though evidenced-based practice is still new to nursing and to the physicians, it is an expectation of our clients.

Some participants felt that educating students regarding contemporary practices and expectations would result in a stronger curriculum. When Saul was asked whether QSEN integration meeting had improved the curriculum, his response was, “I think that anytime safety is incorporated, or safety is further emphasized, I think it’s always stronger because the NCLEX does test the minimum safety standards.” Saul also spoke of informatics and “the digital age that we live in [that] they [students] have to know something about informatics...and it made them more marketable.” Lorna responded to the same question by saying, “I think it [QSEN integration] was very effective – because you have a structure, and its more contemporary,” and Hillary spoke of the benefit of having a “framework” that “helps...to form the objectives and all of them are critical to nursing.” During some of the interviews, brief discussions emerged regarding current trends in healthcare culture such as the rise of patient empowerment, emphasis on utilizing scientific evidence for practice, demand for higher quality care, and the employment of a collaborative approach when providing care. Hillary provided an example in one of her narratives regarding patient empowerment:

I remember being a nurse for many years, I know it was not always patient-centered, it was physician centered...so I know it’s been a big change and it is for the better...[and] I never thought I would live to see the day where I’ll see signs all over the hospital that says, ‘ask your nurse if she has washed her hands.’

Hillary also alluded to changes in performance expectations related to the use of scientific evidence in practice:

Unfortunately, nurses in my generation for years did not read research, we'd go to conferences, whatever the people at the conference told us what the last research was, we took their word for it, and we went back and sometimes we would talk about it and may be, try to apply it – but now, evidenced-based practice is on your license, it's expected that you're going to be guided by the best evidence and take care of your patient.

QSEN's competencies, for example, EBP, informatics, and quality improvement that reflected trends in modern health care received broad positive support by study participants. Hillary explained,

I always tell my students, look at what written on the license because it says you're supposed to do that, and the patients and families are expecting that...so, even though evidenced-based practice is still new to nursing and to the physicians, it is an expectation of our clients.

Saul spoke of the “digital age that we live in,” with students “knowing more about technology,” and the need to teach students about information websites that are “true” and “reputable” that can be utilized for learning and working. Saul also spoke of the benefits students obtain from learning how to document and navigate simulated electronic medical systems because it “makes them [students] more marketable.” When Anna was asked what factors, she believed influenced QSEN integration in the curriculum, she reported that she believed that faculty desired a curriculum that was more

up-to-date and reflected issues that were relevant and on-going in current practice. Lorna echoed a similar statement and noted that QSEN reflected practices that were “more up to date” and “more applicable to what is going on in the real world.” Rhoda, also spoke positively regarding QSEN’s contemporary focus on health systems’ factors noting that students needed to be aware of changes and factors in the health care industry that could impact on their practice. Both Rhoda and Bertha felt that curriculum change was warranted as Rhoda indicated, due to “all the changes in staffing, and all the changes with insurance, and with all the changes...out there in the health care field.” Bertha felt that QSEN represented the “real world experience – what we actually see on the hospital side” and was “a helpful tool to...bridge the gap between what you’re doing in the theory piece...on the side of academia versus what you actually experience, once you get out there and work.” Participants’ overall perspectives revealed that QSEN was thought to bridge deficient gaps in the curriculum that failed to address contemporary issues in health care such as diversity and patient empowerment, informational technology, learning the new focus of teamwork and a collaboration when providing care, and employing an explicit approach to learning and understanding human and system errors that impact on safety and higher quality performance and care.

QSEN posits a broader approach to learning. During the interviews, more than 50% of study participants noted that QSEN’s breadth of knowledge facilitated a broader, deeper, more holistic approach to learning. Because of QSEN’s new definition and orientation regarding patient-centered care, I observed that the introduction of patient-centered care led participants to explore and teach newer and broader concepts

such as culture into the nursing curriculum. I also noted that culture was the most common concept mentioned by participants as they taught patient-centered care. Shelly spoke of teaching “why culture is important” while Harriet spoke of “diversity” in culture. Anna spoke of “recognizing the patients who desired pain relief and non-pharmacological pain relief, assisting them and [providing] family support, while Bertha stressed the concept of the nurse being “authentically present.” Rhoda spoke of a “holistic” approach as:

So...you're treating the mind, the body, the soul, the family, the community, and you're pulling all those aspects of the patient that make them unique, and really trying to incorporate culture, trying to incorporate everything that makes the person who they are, and making it more centered to them...and when we're in clinical, having them [students] look at all those different aspects. How does a patient culture participate in [impact] their plan of care? How is the language barrier? How are their family - important to us? So, to me, that's really the “gist” of patient-centered care. Its holism, its bringing every aspect that makes the patient who they are.

In addition to the expanded teaching and learning associated with patient-centered care, I also observed that QSEN's explicit focus on error prevention, safety, and quality improvement resulted in the introduction of new and deeper curricula content. Study participants admitted to having to develop and implement new pedagogical activities to teach quality and safety principles. Harriet provided one example of having to teach “root cause analysis,” a “concept” in which “students are taught how to conserve

safety and prevent an event from re-occurring.” Harriet also noted, “only recently have we established a QI [quality improvement] form – like I said—we take [it] to clinical [practicum] for the students to follow...we did not do that before, but we do now.” Interviewees spoke of teaching students to understand the importance of “what are the quality indicators on the unit,” “QI proposals,” “sentinel events” and engaging in quality improvement projects such as “data collection” and learning to identify fall risks and pressure ulcers early to promote prevention and enhance care outcomes. Harriet, Hillary, Shelly, and Paula spoke about emphasis on safety when teaching and building students’ practicum skills because of QSEN. Harriet reiterated the new emphasis on safety: “our curriculum currently is based on QSEN. We do stress safety, delivery especially in medication dosage, also in any skill sets that the students may be doing,” and Paula felt that medication errors were decreased because of QSEN’s emphasis on clinical practice. Two participants described students’ behaviors after learning safety as being “more acutely aware of what they are doing...quick to pick on errors...almost to the point of wanting to intervene to make a correction.”

Harriet and Shelly referred to the evidence-based QSEN competency as an inquiry-based approach to learning that allowed “[students] to understand, why they are doing, what they are doing” and facilitated a higher critical thinking process as students learned to assess and implement care. Hillary also explained her method of teaching evidence-based practice: “I actually teach them how to critically read a research article and decide whether or not it’s good enough to guide practice, and I tell them that they’re going to have to know that when they graduate.” Rhoda described her inquiry approach

when teaching EBP as, “trying to pull in and incorporate and have our students look at...say pressure ulcers... “What is the evidence? What does the evidence say is the best practice for treating a Stage II pressure ulcer? A Stage III pressure ulcer?” and Harriet spoke of using an inquiry approach when teaching students how to evaluate the effects of a medication. Two faculty members also reported on the impact of this approach on the quality of their teaching, with Shelly noting that it “absolutely made me more confident; I felt it made me a better teacher...and “as an educator, QSEN gave me more of that critical thinking piece.”

New curricula content such as informatics that participants discussed implementing required teaching students the role of technology in the provision of care, how electronic systems enhance care quality, and skill that utilized a simulated electronic medical record (EMR) system. For example, as Shelly described her experience teaching informatics, she explained:

For informatics, we are using programs so that they can chart and document. Again, that was another one for us, “what is truly informatics?” – it could be EMR, it could be for documentation, but is also getting web based resources, it is also using the medication, drug-Medex – where you’re look up meds for compatibility; I think their knowledge--based on the type of students they are, they understand a lot of technology, but they need to have the understanding that it doesn’t stop there. Informatics is actually very broad – we’re talking about telecommunicating with a patient – telemedicine, there are a lot of things, but for

what we give them, they understand it, but we just touch the tip of the iceberg with informatics for them.

Rhoda and Harriet spoke of the introduction of a simulated EMR into the curriculum “that...helps to get students familiarized with how to use informatics on different levels,” which Rhoda described as “data input” “and...using the computer to get information and to learn about certain things.” Saul described the simulated medical record as,

DocuCare...a digital EMR that students can utilize...like an EMR that they would find at any given clinical agency...students can not only dispense medication using a scanner with a wrist band[when] performing the rights of medication administration, but also document on the entire system for the simulated patient.

Hillary, Lorna, and Paula also spoke of using simulated learning activities and clinical practicum opportunities to teach students teamwork and collaboration skills including learning communication strategies that are employed in the clinical setting. All three faculty members commented regarding the challenge of engaging students in meaningful teamwork and collaboration experiences at the clinical site because of their subordinate position, lack of confidence, and not being perceived as a team member. Shelly alluded to the lack of clarity and confusion surrounding the specific role that practical nurses assume in the clinical setting. She explained: “the PN...they really did not know what part they played in the team, and I think we’re working on, trying to give them a better understanding of what part they play.” Paula commented that for “nursing students, it’s really difficult...I think they get intimidated...they may be afraid to go to

the doctor, or the charge nurse, then they have to report to me,” and Lorna provided similar comments:

students are allowed to go to rounds but they don't have a say; so, they're kind of shadowing teamwork and collaboration, but they're not being part of the process, of being part of a team and collaborating – till they graduate and get to be part of a team.

Despite, however, QSEN's broader scope of knowledge, study participants felt that QSEN by itself was not adequate to learn and achieve competence in nursing practice but required elements in the standard curriculum. As Shelly explained,

I think that QSEN is better...because it's more general...[however], you have to still know the pathophysiology, you have to still know everything that's in the standard nursing curriculum to be able to process and understand the competencies... It's not just saying, OK, we're going to study stroke, we're just going to talk about this. No, when we study stroke, we are going to study QI [quality improvement], safety, so think of everything that can go under safety.

Lorna, Rhoda, and Bertha also concurred that the standard nursing curriculum comprised of maternal newborn, psychiatry, pediatrics, adult medical- surgical courses were essential although QSEN facilitated a comprehensive approach to learning. Rhoda explained,

So, I can't answer to just having a QSEN curriculum, because you still have to teach the students about med-surg... I think they need that content, but we're using more of a QSEN focus – so for instance, you're going to teach someone

about heart failure, CHF [congestive heart failure], so you teach them what they need to know about CHF but you can bring the QSEN core competencies into what you teach – but they still need to know about the signs and symptoms of CHF – how do you intervene- what do you do, what are you looking for as a nurse, what’s your priority, so I sort of see it [QSEN] as going together.

Lorna felt that the standard curriculum was needed although QSEN was thought to enhance the curriculum:

I think the old traditional nursing curriculum still works when it comes to organizing your course, but then QSEN...helps with the content that you’re delivering...it’s not just talking about [a] specific disease process and what are you doing, and pharmacology and that’s it...you’re broader now, so you talk about the EMR you talk about the different members of the team, you talk quality and safety in relation to any type of intervention that you’re doing for a specific disease process...so you go beyond the traditional anatomy and physiology, patho [pathophysiology], pharmacology, nursing interventions. I concluded that QSEN’s integration into the standard curriculum added synergy to the overall curriculum due to the broader and deeper concepts that embody the QSEN competencies of patient-centered care, teamwork and collaboration, evidenced-based care, safety, quality improvement, and informatics.

General findings suggested that participants favored QSEN because QSEN reflected foundational elements in nursing that filled and bridged curricular gaps and

posited a broader approach to learning. In the following section, I discuss participants' perspectives concerning the QSEN integration process.

Central Research Question 1: Faculty Members' Perspectives Integrating QSEN

The original research question for this study was: what are faculty members' perspectives integrating quality and safety education for nurses (QSEN) as a curricular framework for a nursing program curriculum? In the previous section, I addressed aspects that pertain to participants' overall beliefs and attitudes about QSEN because attitudes and beliefs provide a context and facilitates deeper understanding of participants' responses as they described their experiences and methods employed to integrate QSEN. Two main themes emerged from the in-depth analyses: QSEN integration is complex and QSEN integration is a process. Within the first main theme, "QSEN integration is complex," I have included subthemes "faculty preparation," "translating QSEN," "implementing QSEN," "faculty's knowledge," and "limited experiential learning opportunities" that further explain the nature of the complexity of the integration process.

QSEN integration is complex. When faculty members were asked to describe what they recalled about the integration process, two-thirds of participants suggested that the QSEN integration process was complex; some of the words used by different participants to describe the process were, "arduous," "tedious," "painful," "a fine-tooth comb," "challenging," "convoluted," and "frustrating." The structural process employed to merge the QSEN competencies into the curriculum occurred either through regularly scheduled faculty staff meetings or nursing curriculum committee meetings. The

subthemes that emerged were based on participants' feedback and pertained to faculty preparation prior to the integration process and implementing QSEN into the classroom.

Faculty preparation. Several participants alluded to the need for adequate faculty education to successfully integrate QSEN into the curriculum and classroom didactics. At the initial stage of QSEN integration, five out of nine faculty members had minimal to no prior knowledge of QSEN, while four participants reported that they had some knowledge from their hospital experience or from higher education. Shelly spoke of her lack of experience as a new faculty member with the curriculum change process, coupled with her limited knowledge of QSEN, as her source of frustration with the integration process. She explained that she was used to “researching things a lot,” and felt there was too much “redoing work” and revising course objectives. She explained, “so, for me, the process could have been better with more prework, more preunderstanding...so, I think in the beginning of the process, we as faculty, and I am speaking for myself, did not fully understand.” Paula also echoed similar thoughts when she was asked to reflect on the integration process. She recalled at the start of the process, it was “challenging,” “difficult at first,” having to do “a lot of work,” “it was kind of convoluted, [and] a lot of faculty did not understand it, including myself.”

Four participants spoke of educating faculty as a pathway to obtaining faculty “buy-in” or consensus and to overcome resistance to curriculum change. Lorna emphasized “educating faculty” as “key” and reasoned that background knowledge such as “being familiar with the literature” and “understanding where this came from” would increase appreciation for QSEN and make “the process much easier,” while Paula spoke

about the importance of “workshop and seminars” and recommended “6 months to a year” of faculty education before commencing integration. Hillary also cited “education of the staff” as a factor in averting initial resistance to change and for promoting consensus among staff. Both Hillary and Rhoda defined staff education as related to understanding, “what it [QSEN] is, how is it’s been used so far, what other people’s success have been with it,” how QSEN has affected “patient outcomes,” including how QSEN has been applied and utilized at other “major colleges and universities” and “nursing programs.”

In addition to the need for faculty education about QSEN, I found that team spirit was an essential element at the onset of QSEN integration and that lack of faculty engagement was reported to lead to resistance and overall dissatisfaction with the process. Saul’s reflection of the initial integration process was described as “hectic” and “disorganized” and related that the decision for change was more of a “discussion-directive,” such that participants did not know “as much” as they “should have prior to incorporating [QSEN] into our curriculum.” Saul further explicated, “I wanted to look at it [and] analyze it; I did not want it [QSEN] just to be shoved down my throat.” Paula also noted that the decision to change was made in part due to accrediting requirements and the “Dean decided that he would like it to be introduced and...rolled out into the curriculum.” Both participants indicated that they perceived curriculum change as “additional work,” although Bertha expressed her dissatisfaction with the roll out at the start of the integration process:

It's how it's introduced to faculty, that's going to determine the buy-in. If we...introduce it properly, or in a way where people will be more willing to embrace...whether its technology, if it's a concept like QSEN...it depends on how it's introduced to the faculty. As opposed to telling them, this is the new way, this is how we're doing things, but really giving some back drop of information as to why it's important and how it's going to impact the students' experience, I think you will garner more willingness to embrace anything new in academia. People have done things the way they have done them for a long time, and that's what people are used to, accustomed to. Things we also have to take into consideration as well is, this is an intergenerational group...so there are people who are not computer savvy...so, when we go to introduce these new concepts...and try to incorporate them into what we do...it can be concerning. Again, if it is not done in a very sensitive way, and we've seen that.

Both Paula and Bertha suggested implementing a "pilot program" and "opportunities to test...these...initiatives..." to avoid a "hard transition," and although Paula, Saul, and Lorna spoke about the workload, there was consensus among participants that the process of integrating QSEN was well worth the time and effort. To the contrary, Rhoda, Anna, and Bertha felt that QSEN was inherent in the nursing program curriculum and did not increase their workload. Further in-depth discussions as the interviews progressed revealed that three participants reported ambivalence in the early stages of QSEN integration related to lack of adequate preparation, knowledge, and active engagement in the change process. The following section describes the subtheme

of additional challenges encountered when translating and implementing QSEN into the curriculum and classroom.

Translating QSEN. The interviews as I asked participants to explain how they integrated QSEN, participants reported they experienced several challenges as they translated QSEN to formulate, synthesize, and level new course objectives across their curriculum and nursing programs. Participants reported that the curriculum change process involved several steps, one of which was revising and synthesizing standard course objectives, and program, and student learning outcomes to reflect each QSEN competency. Shelly described the process:

so, it included a lot of different parts – looking at the [QSEN] competency...the curriculum...the content... classroom activity...we had to figure out what content we were actually teaching, how it related...specifically to whatever [was the] QSEN objective...we had to see what in the curriculum...addressed safety... and how were we evaluating...the students...The job was to go through each [QSEN]competency, match them with our student learning outcomes... We decided that each SLO should address something that QSEN says was relevant.

Paula described the process as: “[you] look at the [QSEN] content...the KSAs...the knowledge, skills, and attitudes... look at the [standard] objectives...and it had to match the outcomes in the syllabus.” Saul spoke of revising the “syllabi” that he described as the “course description” and “learning outcomes.” Rhoda described the format as a staff meeting having a facilitator with participants providing input and

feedback from staff on methods they employed to integrate QSEN into their individual courses and clinical practicum. She explained,

so, we were all asked to give our input for the courses that we teach...starting at the LPN level and going all the way up to the bachelor level...look at each course lecture... clinical...and simulation...to see how we're incorporating quality and safety into the whole curriculum. Data analysis of participants' descriptive language, explained as "a lot of work" and "fine tooth comb," pertained to how participants went about selecting and examining the syllabi, related text books, and learning resources to determine what and how QSEN content was addressed, and the subsequent development of pedagogical strategies and evaluation methods they employed to evaluate learning.

Participants spoke of the challenges that they experienced during the integration process regarding aligning course objectives with QSEN competencies to reflect appropriate program level and formulate new learning outcomes. Hillary spoke of weekly meetings that occurred over "a long time" to "redo" and "integrate" information into the curriculum, that she described as the "hardest part." Hillary also spoke of the "arduous" process of utilizing Bloom's "text" and "verbs" to incorporate QSEN. She explained, "we had Bloom's text and... so, you...kind of have to arrange the objectives based on Bloom's taxonomy...but it's good to know about its comprehension, application, and support..." When I asked Shelly for her feedback on the use of Bloom's taxonomy during QSEN integration, she responded: "so Bloom's did help...create our SLOs and say, this is what we're doing, but, in essence – we still had to ask, "does this student

learning outcome address this [QSEN] competency no matter what verb you use to do it?” Although Harriett did not discuss her perspectives of Bloom’s taxonomy, her views described the complexity she associated with reconstructing the curriculum:

well, I think the hardest part was just trying to get it [QSEN] to mesh up to the curriculum...so, when you set up the syllabi and you were reading it, it had to reflect QSEN and I don’t think it had been done in the past...but, what we found was, we had to change the wording...of the descriptions in the subject so that it would show the incorporation of QSEN.

Lorna described the complexity of levelling the QSEN competencies according to students’ placement in their nursing program by having to utilize descriptive words that revealed the degree of progression as QSEN’s knowledge, skills, and attitudes were threaded through the nursing program. Lorna described it as: “so, kind of understanding what feeds where, when it comes to every individual course, especially for the specialty courses – it was very hard, and, also levelling your QSEN...objectives because you had to show some progression.” Shelly also referred to challenges related to levelling and evaluation of learning. She noted: “we really didn’t know how the [QSEN] competencies will relate to the students we were teaching, and how we could make sure they [students] met the competencies based on the curriculum that we had.”

Shelly spoke about the challenges when integrating QSEN into a licensed practical nurse program because of limitations in scope of nursing practice for licensed practice nurses. She elaborated,

I think inherently, the PN program had challenges...because of the limitations of the scope of practice. So, when we are talking about things such as, inter-professional nursing, and the role of the PN in that process...it [was] a little difficult to say, “OK, how can this competency translate into an SLO [student learning outcome], and how can the student actually get it...and I think we are still struggling with that.

The challenge of consensus gaining among nursing faculty members regarding curricula content and program alignment often saw episodes of disagreement as described by Lorna, who associated conflict with the challenge of embracing curricula change:

so, there were issues detaching, there were a little bit of conflict – they were professional, we didn’t always agree, and also, when we did our SLOs, we only wanted one, ‘max’ two SLOs per QSEN competency, and then we had so many...there was conflict because we were eliminating some of our old SLOs to make them QSEN...and then I think we had issues detaching from the old and integrating the new.

Saul spoke of integrating QSEN as impacting on the liberty of teachers and spoke of the loss of academic freedom because of the new structured approach stating:

the whole point of going into academia is to have the academic freedom to do and to run your courses and to teach the way that you see fit that will benefit the student...when you have someone who is giving you a curriculum...it may impact on your academic freedom, so of course you are going to get resistance!

Bertha spoke of general concerns that accompany curriculum change. She explained, “when we go to introduce these new concepts... into what we do, and how we practice, and how they practice, it can be concerning.” Some challenges that occurred during QSEN integration pertained to maintaining effective team spirit and dialogue for gaining consensus in determining, developing, and leveling curricula content to meet nursing program standards. In the following subtheme, I discuss additional challenges associated with implementing QSEN in didactics and clinical practicum learning.

Implementing QSEN brought challenges. Data analysis revealed that as participants sought to integrate QSEN, they experienced challenges associated with implementing pedagogical strategies and spoke of limitations associated with experiential learning opportunities and faculty’s expertise to develop competence in quality and safety concepts. Some participants spoke about daunting issues when integrating QSEN into didactics and simulation, including developing teaching strategies especially for specialized courses with limited credit hours and time for teaching. Lorna elaborated:

There is a challenge when you need to customize it for your course. When you read the competency it’s self-explanatory, they’re easy to understand, but you really have to put it in your objectives and in your evaluation, you need to be honest...you can’t be putting down, ‘Oh, my students are competent in interdisciplinary communication,’ if it’s not really happening. So, making sure that you’re able to customize it to your course and most importantly - that you’re able to deliver, whatever you need to deliver in order to meet the objectives – I

think that's the challenge, we need to make sure that those strategies are being utilized to teach what we are intending to teach.

Shelly also spoke of her struggle to determine how to create the content, deliver the material...in the classroom...clinical setting...[and] lab, and determine what was needed "to...meet the course objectives...[so] that "the students can...meet the competencies...I think it takes some practice, and it takes mentoring to." Rhoda stated that her primary challenge was to "determine how to incorporate QSEN into nursing courses such as fundamentals and "med-surg." and decide what method she will employ "to help them [students] understand."

Paula spoke of utilizing mentors who were faculty members who volunteered to learn about QSEN and who provided support during the integration process. She noted, "we did not feel all alone...and...at least I had someone who I could call on... they could come over and eye-ball my syllabus...my power point, they could sit in the class, they could give me feedback...so, it was really powerful." Seven out of nine participants referred to textbooks as a primary resource they employed to integrate QSEN in the classroom and spoke of other sources that included case studies, videos, discussion, and simulation. Although most participants were aware of the information-rich QSEN website, none admitted to utilizing the QSEN website as a resource for teaching and learning.

In addition to developing and implementing teaching strategies, some participants spoke of workload and time constraints as limiting factors when implementing QSEN. Four participants spoke of the workload involved in integrating QSEN as being a

challenge and that it should be reduced during curriculum change. Two interviewees felt that the workload or credit load should be decreased during the change process to enhance QSEN implementation. Three participants commented on time limitations as they related to “teaching” in an already saturated curriculum, during course preparation described as doing the “research,” when developing content, and engaging learning activities. As Saul explained, “You have a limited time to teach X [number] of concepts in the didactic portion of the course, so just adding more to it is just [laughing] is the straw that breaks the camel back.” Lorna echoed a similar comment regarding teaching:

if we have a 2-hour lecture and we have to cover two systems, do we really have time to stop and ask the student to go over a case study to promote quality and safety? Or write something about interdisciplinary team members? So, I think the challenge is finding the right teaching/learning strategies to teach QSEN.

Participants spoke of several challenges implementing QSEN associated with curriculum development and system related factors such as workload and time to teach. In the following, I discuss participants’ views regarding their knowledge about QSEN.

Faculty’s knowledge of QSEN is important. At least three interviewees spoke about the importance of faculty’s expertise in QSEN to effectively teach the QSEN competencies. When Rhoda was asked what was most challenging about teaching QSEN, she admitted to needing to know and understand QSEN fundamental concepts such as, “why is evidenced-based practice, or patient-centered care, or teamwork and collaboration so important? She explained,

well, I think first and foremost, it's just me myself knowing what it is, and knowing its purpose, knowing its goal. It's me getting the knowledge first, because if I don't really have the knowledge, and I don't understand something, then I can't deliver that to my students. So, to me, the most challenging thing is my understanding it and getting that knowledge, so I can deliver it to them...if I don't really have the knowledge, and I don't understand something, then I can't deliver that to my students...once I get it, then I am in a better position to give it to them.

Shelly also spoke of having to understand first what the competencies meant, and what the students needed to learn to achieve a specific competency, and then create it, because QSEN was different than a "checklist." Lorna noted regarding informatics that she had "done a lot of reading, training, and...still [needed] learning because it "was almost like brand new." Additionally, she spoke of challenges associated with teaching EBP at the beginner level due to some faculty's failure to understand the fundamentals and scope of the evidence-based competency. In relation to quality improvement, one participant felt that quality improvement was difficult to teach because she saw it as more "theoretical as opposed to clinical...[its] all about discussion, yes, you see things at the unit, you come back, you discuss it, to me, OK, discussion is good, but I like to do discussion followed by demonstration."

At least 6 out of 9 interviewees admitted that some competencies were more challenging to teach than others. Of the competencies mentioned, the most challenging to teach were quality improvement and informatics compared to patient-centered care,

safety, and teamwork and collaboration, although two faculty members, Paul and Lorna, spoke of their strong interest in informatics. Some of difficulties that interviewees mentioned pertained to “demonstrating” how to teach and extract QI [quality improvement] learning experiences at the beginning stages in simulation and clinical practicum. Regarding informational technology, I observed that two participants, shared a common assumption concerning senior faculty “teaching for 20, 30 years” and their limited abilities to teach informatics, and one of the two participants, Lorna spoke of the frustration she experienced with newer adjunct faculty concerning lacking competence and interest in informatics. Lorna described her experience with faculty.

I experience a lot of difficulties related to buy-in – faculty buy-in, because in order for you to teach informatics, you’ve got to be competent with. So, how are you going to teach something that you don’t really feel comfortable with? So, I know for the student EMR - DocuCare – especially with the adjuncts, it took us a while to roll that out and even so, we’re still having some issues with the DocuCare – which is the students’ EMR - and then you still get students’ complaints about not getting enough guidance.

QSEN implementation was directly connected to faculty’s knowledge and understanding of the QSEN concepts, and mentoring was cited as effective for those new to QSEN and adjunct faculty. Some competencies were easier to teach and devising instructional strategies were difficult. An additional challenge cited by participants pertained to limited learning experiences to develop students’ quality and competencies.

Limited experiential learning opportunities. Data analysis regarding factors that impacted on QSEN integration as reported by interviewees was that some of the competencies such as teamwork and collaboration and informatics required learning experiences and mentorship in the clinical setting for adequate competency development. Participants spoke of not having “enough experiences” to learn teamwork and collaboration and that students needed to “experience working in that particular environment to see the benefit” of teamwork and collaboration. However, Lorna noted, “students are excluded from many different learning experiences that we got in the past” alluding to the hospital-based training that occurred in prior years. Both Hillary and Paula spoke of limited interaction and actual learning experiences with members of the health care team for students’ competency development in teamwork and collaboration skills. Hillary explained this dilemma:

I think the main thing is making that reality – and I think when we bring students to the bedside, it’s difficult to meet the criteria. I was just looking at this now – teamwork and collaboration – the students aren’t considered part of the team, even though they are there, and I think they hesitate to express their opinion to a physician...and...I’ll bring them over and say, ‘well tell the doctor what you just found’ and [then] they look at me like...me?...but teamwork and collaboration starts as a student to nurse, it doesn’t just start when you graduate.

Paula and Lorna talked about the lack of interaction and poor professional relations between students and physicians that impact on learning:

well for nursing students it's really difficult, they don't understand. I think they get intimidated. But what we reinforce is that – if anything is out of the normal, and yes, they may be afraid to go to the doctor...charge nurse...then they have to report to me. So, what we do, we do case studies, role play, and discussion to bring home collaboration.

Bertha and Hillary spoke regarding the impact of cultural practices at clinical sites and its effect on teaching and learning teamwork and collaboration: “we fall short...because it's hard for them to see it, when they go to the clinical area.” Hillary went on to relate her experience regarding team spirit at one institution:

one hospital I went to and the main person running it was a social worker, and the physician was just saying what the plan was for the patient – I didn't even hear a nurse who was part of the staff, giving any information to what they were saying – so if the students were looking at the nurse as role models, they would think – well, unless someone ask me directly...

The clinical site was felt to be a primary source for learning opportunities for students to develop skills in informatics, EBP, teamwork and collaboration, and quality improvement. Lorna spoke of limitations in learning informatics because “students don't have access to the EMR in the hospital,” while a second participant spoke concerning the failure to emphasize EBP in the clinical setting: Hillary noted, “I actually teach them [students] how to critically read a research article and decide whether or not it's good enough to guide practice...and yet I don't know how much of the care rendered by nurses

I see in the clinical setting – I don't know how much of what they do is evidenced based or if they think about [it].”

In the following section, I will explore and describe participants' reflective analysis of the initial QSEN roll out and implementation experience. I will also discuss components of QSEN integration that participants viewed as a process, including how they viewed their professional development in QSEN concepts and principles.

QSEN integration is a process. This second theme relates to the first research question that addresses participants' perception that QSEN integration is a process that should be implemented gradually for both pedagogy and faculty development. Both Paula and Bertha spoke of the QSEN introduction process and felt in retrospect, it should have been a gradual process. Paula described the start of the integration process that she was engaged in as a time of “trial and error” that started at the foundation level and gradually expanded to the entire curriculum. She also noted that not having a “pilot program” was a “problem,” while Bertha talked about introducing change “properly” as taking “baby steps,” with a period of testing “[QSEN] in a very neutral environment.” Bertha explained, if “we don't have that, it's going to be a hard transition.”

Workload and time, common patterns echoed during discussions about QSEN integration, were associated with the teaching, learning, and integration of QSEN. For example, Saul and Shelly found that time was needed to develop pedagogical strategies requiring “at least three or four semesters worth of running a course...where you feel comfortable with that material that you're teaching.” Paula spoke of new faculty needing “extra time,” because “it takes time to learn about it, and understand it yourself, in order

to demonstrate it, and teach to the students.” One participant felt the integration process did not occur at the right time because, “it was right around finals and it was right around major milestone type events.” Hillary spoke of QSEN integration as a “process” that was ongoing. As she explained:

Well I know that initially we had cultural care competencies intertwined, we did it as much as possible...I think it's pretty much pervasive throughout the curriculum now...In fact, even in courses where we thought we really could not get it in, even in my nursing theory class, QSEN seem to work really well there and we incorporated that...and...this term, we're going to be teaching safety in terms of the bundles – the QI monitoring, and that's another QSEN.

Additionally, some of the participants noted that obtaining experiential learning at clinical sites has been a gradual process as clinical sites progressively adapted QSEN principles in their daily practice. One interviewee spoke positively concerning students' learning experiences at one clinical facility because of faculty and administrators' engagement in quality improvement practices. To the contrary, however, opportunities for learning and observing some QSEN principles such as teamwork and collaboration were limited due to the absence of team spirit in certain nursing units except for such units such as the intensive care unit and the emergency room.

In addition to the teaching and learning of QSEN concepts, faculty's development and competence in QSEN was also viewed as a process. As Paula explained, “it takes time to learn about it and understand it yourself, in order to demonstrate it, and teach to the students,” while both Hillary and Bertha attributed their years of clinical experience

as a contributing factor to their QSEN expertise. Hillary explained, “I think I’m lucky in that I have so many years of clinical experience [such that] I have an example for all these things all the time and especially now, we talk a lot about root-cause analysis.” It is interesting to note that at least three participants recommended the availability of resources such as seminars, and workshops, and visiting schools and other facilities that have implemented to better “understand “how they’re using it... how they’ve incorporated it, [and] what methodologies they are using,” to enhance faculty’s expertise. Paula spoke positively of her institution that utilized staff who volunteered to learn QSEN and who became “power users” so that they could work “one-on-one” with faculty during the early stages of QSEN integration. Paula noted that having “power users” - was very effective in providing guidance and support for faculty members. Lorna summed up the process of QSEN integration as “I think we’re getting more used to having it incorporated and it’s become part of what we speak to.”

Components of QSEN integration such as faculty expertise in learning and teaching QSEN, curriculum development, and the availability of clinical sites that demonstrate quality and safety practices for student learning were perceived as a process that occurred over time on both campuses. In Subquestion 2, I discuss participants’ perception of their role in the process of QSEN integration.

Subquestion 2: Faculty Role Perception in Curricular Change

Research Subquestion 2 was: How do faculty members perceive their role in curricular change? Faculty perceived that they have a major stake in creating and shaping the curriculum and are at the helm of curricular reform, which is the one theme

related to this subquestion. Participants provided descriptive salient words in response to the interview question regarding faculty's role in curriculum change. Some examples of explanatory phrases were "create that framework," "design and shape," "feed and starve the curriculum," and "we develop the curriculum...make changes...teach it... we do it all...we...make it happen."

All participants agreed that faculty were the best agent for incorporating curriculum change. Saul spoke of the fluidity of the curriculum and the reciprocal influence of faculty on the curriculum and the curriculum on faculty. Both Saul and Harriet noted that faculty influenced the curriculum by determining its "framework" and "its design and shape," while "...newer information...technology... pharmaceuticals...methodologies...new and faster techniques were thought to be curricular factors that influence faculty in how they create the curriculum.

In relation to QSEN integration, generally all faculty spoke of their role in developing the content, incorporating and implementing the competencies, and facilitating learning. Lorna spoke of the influence of faculty on future practice.

We develop our curriculum...evaluate it...make changes...teach it. We do it all.

If we don't do it, then who's going to do it? It's not like in the hospital where again you had all these concepts – not personally - but I saw a lot of people not adhere to some recommendations, but here in nursing education you are at a different level, you're responsible to help the nursing profession grow...if we don't do it, it's not going to happen, and then we're going to have an impact

because we are training nurses who understand, implement, apply and appreciate QSEN.

Participants also perceived their role as intimately connected with their job function and perceived curriculum change as one aspect of their duties. As Saul noted: so, there's always things that shape the curriculum that we as educators have a responsibility to at least need to know about or learn – so that we can impart that knowledge unto our students.

Participants generally felt curriculum change was a primary responsibility and all agreed that they were responsible for curriculum changes, teaching the curriculum, and evaluate students' learning and progress, as well as ensuring the curriculum were up to date, and relevant for practice. QSEN integration was perceived by participants on both campuses as complex and a process. In relation to faculty's attitudes and how they perceived their role in curricular change, study findings revealed that faculty generally felt positive about QSEN, that they played an active role, and were at the helm of curricular reform; in addition, faculty also perceived their role in curricular change as an integral part of their responsibility.

In Chapter 5, I will describe and interpret my findings in relation to current research about QSEN and the context of the conceptual framework. I will also discuss study limitations, recommendations for future research, and implications for positive social change in the field of nursing education. I conclude with a strong stance regarding broad support for faculty members who are primary stakeholders in the phenomenon of curricula reform.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this basic qualitative interpretive study was to understand the perspectives and attitudes of faculty as they integrated QSEN competencies into their existing nursing curriculum. The introduction of QSEN among schools of nursing has been gradually expanding since the IOM's call for reform in how students of health professions are prepared for practice (Sherwood & Zomorodi, 2014). Faculty members are primary stakeholders in nursing education; however, their perspectives and attitudes as they integrated QSEN to reform their nursing program curriculum have been minimally explored.

In this study, I employed the use of an interview guide with semistructured, open-ended questions for this qualitative inquiry design. Using a deductive approach, I extrapolated categories of similar data from participants' responses to develop themes that reflected the perspectives, beliefs, and attitudes of nursing faculty members as they integrated QSEN into their nursing curriculum. I also compare the broad and key study results to the findings of established studies about QSEN.

Summary of Findings

My findings related to the primary research question regarding faculty's perspectives as they integrated QSEN competencies as a curricula framework were that faculty felt that QSEN integration was both complex and a process. Participants spoke of the challenges they encountered as they reconstructed their curriculum, courses, and program outcomes to reflect the QSEN competencies. Faculty also noted that additional

challenges pertaining to the complexity of QSEN integration involved levelling the competencies to match students' program level, developing pedagogical strategies to learn QSEN, obtaining appropriate experiential learning opportunities at clinical sites for competency development, and having adequate time for teaching in a saturated curriculum. Faculty also spoke of their lack of knowledge and expertise in QSEN, which some thought had contributed to the complexity of the integration process.

Study findings that answered the primary research question concerning faculty perspectives of QSEN integration suggested that QSEN was a process and time was needed for faculty's professional development and expertise in QSEN principles and concepts and for the integration of QSEN across the curriculum.

The three key findings related to Subquestion 1 that addressed faculty members' attitudes concerning curricular change suggested that first, faculty generally felt positive about QSEN integration due to their beliefs that QSEN was similar to nursing and reflected fundamental nursing principles that had been a part of nursing curriculum. Secondly, faculty felt that QSEN helped to fill gaps that existed in the standard curriculum that related to learning knowledge, skills, and attitudes of newer and changing standards and practices within health care in areas of patient empowerment; EBP; teamwork and collaboration; informational technology, including safety; and quality improvement. A third key finding related to Subquestion 1 was that QSEN posited a broader and holistic approach to student learning that encompassed the learning and application of nursing science within the context of a wider QSEN curriculum framework. Regarding Subquestion 2 that addressed how faculty members perceived

their role in curricular change, I found that faculty generally felt that they played a salient role and were at the helm of the curricula change process.

Interpretation of Findings

The results of this qualitative inquiry confirmed my findings from the literature review that addressed the challenges in nursing education that fueled the introduction of QSEN and the challenges associated with the integration process. In this section, I will present my findings by discussing common themes that were shared by both the literature review framework and the results of this study. I will also analyze the study findings within the context of the conceptual framework regarding Senge's (2006) principles of learning organizations and Benner's (2001) model of professional skill development.

The Need for Curricular Reform

The need for curricular reform among schools of nursing was a salient theme found in the peer-reviewed literature and in this study and confirmed that nursing students, nurses, and faculty members were generally dissatisfied with the standard curricula structure and content. Gaps in error prevention teaching in nursing curricula were cited in several studies (Farley et al., 2013; Hsaio et al., 2009; Tregunno et al., 2014). Vaismoradi et al. (2014), who obtained Iranian nursing students' perspectives about pedagogical strategies to learn safety concepts coupled with their expectations of a new curriculum, deduced that students' desire for greater safety content and more targeted practicum experiences were related to curricula content and how clinical practicum experiences were organized. In my study that focused on nursing instructors, I found that although all instructors felt that safety concepts, including patient-centered

care concepts, were always taught in nursing education, because safety and patient care have been inherent elements in nursing, they concurred with the findings of these cited peer-reviewed studies in that they felt the curriculum did not explicitly address and teach safety and error prevention concepts. Study participants felt that the QSEN's safety competency introduced safety and error prevention on a broader scope that incorporated the influence and performance of individuals and systems to facilitate a holistic approach for safety and error prevention teaching and learning.

Nurse stress and medication errors were attributed to lack of adequate knowledge about high alert medications from poor curricula structure and insufficient time to learn pharmacology (Lo et al., 2013). In this study, at least one third of faculty members also spoke of insufficient time to implement instructional strategies to adequately teach safety concepts, which they attributed to a saturated curriculum and decreased credit hours to teach certain courses at clinical learning sites. In addition, they thought insufficient training time was a barrier for adequate skill development.

Like the Barton et al.'s (2009) Delphi study that found differences among study participants' perspectives regarding placement of QSEN competencies in the curriculum, I also found differences in faculty's perspectives at one of the colleges where I collected data regarding when QSEN competencies should be introduced or emphasized in the curriculum. During the interviews, two faculty members spoke of different times when certain competencies should be taught or emphasized. For example, Saul spoke of safety and patient-centered care as fundamental concepts and appropriate for teaching at a PN program level with EBP and quality improvement learning appropriate for the RN,

whereas Shelly spoke of her experience engaging her PN students in quality improvement initiatives and narrated positive learning experiences.

Insufficient knowledge about health care systems were cited as curricula gaps in studies such as Dolansky et al. (2013) and Duclos-Miller, (2011). Participants in this study spoke of desiring a curriculum that posited a holistic view to learn nursing care within the context of the individual patient, the health care system, and teams within the system. Like the peer-reviewed literature, faculty concurred that the standard nursing curriculum was limited to the contents of the subject matter that was studied and that the curriculum needed to reflect current trends in health care such as contemporary practices and standards that impacted on students' future practice.

Faculty Preparation and Training

Consistent with findings regarding faculty's lack of training and understanding of QSEN concepts (Barnsteiner et al., 2013; Cronenwett et al., 2007; Morris & Hancock, 2013; Sherwood, 2011), I found that at the time of the roll out of QSEN integration into the curriculum, participants perceived they had limited to no knowledge of QSEN competencies and did not understand or could not define the QSEN competencies nor articulate their importance. Corroborating studies (i.e., Bryer et al., 2014; Cabaniss et al., 2014; Hung et al., 2015) reported that prior to attending workshops, faculty had experienced challenges developing objectives, course assignments, and teaching and expressed concern regarding their readiness to teach. In this study, I found that for those faculty members who did not have background knowledge in QSEN from their graduate education, their preparation and training in QSEN were minimal and limited to a

workshop, webinar, seminar, or individual learning from textbooks. Additionally, six participants agreed that educating faculty was a key facilitating factor in increasing QSEN integration across the curriculum, contributed to faculty buy-in, and recommended “educating faculty” as an important factor in enhancing future curricula change activities. Additional insight obtained from participants in this study (Paula, Shelly, Saul) was that lack of knowledge about QSEN added complexity to the initial roll out and implementation process.

In their QSEN integration studies, both Pollard et al. (2014) and Zeind et al. (2012) noted that although faculty desired to integrate QSEN across their curriculum, some QSEN competencies such as quality improvement and informatics were not present, and faculty admitted to not having the expertise in those competencies including EBP. Of the six QSEN competencies discussed in the research interviews, participants also reported informatics and quality improvement as most challenging to teach, followed by EBP. They reported that these challenges were related to their misunderstanding of the concept, deciding what and how to teach, and finding appropriate learning experiences to achieve the skills required for competency development.

Altmiller and Armstrong (2017) surveyed faculty for their perspectives on facilitating factors to successfully implement QSEN and noted that 75% of the respondents reported faculty education; faculty development; and use of educational resources, such as instructional strategies, course guides, case studies, lesson plan, and modules, for both faculty and students as key factors (p. S5). I also obtained similar recommendations when I asked faculty members what would improve future curricula

integration processes. Some responses faculty provided were: attending workshops, seminars, instruction in pedagogical strategies, and obtaining information from different nursing programs that had successfully integrated QSEN.

Challenges in QSEN Implementation

Cronenwett et al. (2009) and Pollard et al. (2014) found that QSEN curricula redesign was a daunting process, and the results of my study further authenticated those findings by faculty's description of the initial QSEN curricula integration process as being "arduous," "tedious," "painful," "challenging," "convoluted," and "frustrating." Similar to the research findings of Bryer and Peterson-Graziose (2014), Hickey et al. (2010), Pohl et al. (2009), and Pollard et al. (2014), participants in this study expressed challenges when translating QSEN into the curriculum, such as revising the curriculum framework; creating new course objectives; identifying and developing appropriate learning strategies for classroom; clinical practicum; simulation learning experiences, including leveling the competencies according to the program level; and developing evaluation methods. Additionally, lack of experience with the curriculum change process was one source of limitation and challenge for new faculty members during the reform process.

Researchers in related studies found that some competencies such as quality improvement and informatics were consistently reported by faculty members as more challenging to teach compared to other QSEN competencies (Pollard et al., 2014; Thornlow & McGuinn, 2010; Zeind et al., 2012). Some competencies, such as teamwork and collaboration and informatics, were emphasized more in the clinical setting (Cabanis,

2014). In this study, faculty members believed some competencies related to teamwork and collaboration and informatics required clinical setting learning experiences for adequate skill development and appreciation.

Regarding QSEN implementation, Headrick et al. (2012), Tregunno et al. (2014), and Sullivan (2010) addressed challenges in obtaining effective experiential learning opportunities at clinical sites to develop skills of teamwork and collaboration and informatics. These researchers reported limitations in learning impacted by cultural silos, a paucity of sites for experiential learning, and institutional policies and needs. During the interviews for this study, the participants spoke of barriers to meaningful learning at clinical sites related to existing cultural silos such as the absence of nurses during interdisciplinary team meeting to demonstrate skills of teamwork and collaboration, the perception of students as not being members of a team and lacking a voice such that students are not empowered to participate in team work, power imbalances between student and physicians, and the absence of nurses who can address and demonstrate EBP at the bedside.

System Related Factors

Brady (2011), Disch et al. (2013), and Ellis (2013) reported that organizational variables related to leadership support, resource availability for teaching, faculty development, limited workforce, and workload were salient factors influencing QSEN integration. Zelenikova et al. (2014) deduced that access to resources promoted faculty's positive perception about QSEN and the organization's vision, although Disch et al. reported that faculty attributed their success to strong, engaging, and supportive

leadership, access to resources, and opportunities for professional development. Like Zelenikova et al. and Disch et al., leadership support of training programs and their active engagement in QSEN integration promoted positive responses from participants in this study about QSEN integration. Participants spoke positively of training programs such as “train-the-trainer” initiatives that the dean initiated and supported, including engaging in identifying and addressing gaps in faculty knowledge about QSEN; serving as facilitator at curriculum integration meetings; and facilitating access to resources such as workshop training, financial support, and instructional materials for teaching and learning. Like findings from the studies by Brady, Disch et al., and Ellis, challenges in the QSEN implementation found in this study were related to heavy workload, a saturated curriculum, and the time needed to learn the QSEN competencies. Additional concerns raised by participants were related to the limited time to engage students in diverse interactive learning activities for adequate training and skill development in the QSEN competencies.

How leaders communicated their vision was a salient factor that impacted faculty attitudes at the onset and during the curriculum change process. In this study, participants expressed dissatisfaction regarding the communication process during the initial QSEN roll out because participants wanted to be engaged in the change and decision-making process. Participants felt that effective communication was essential for faculty “buy-in” and to gain consensus. For example, Saul expressed dissatisfaction of not having the evidence regarding “the curriculum not working,” and learning QSEN to make “an informed decision.”

At the initial roll out, some participants felt unprepared because they were unfamiliar with QSEN, had limited experience teaching QSEN, and were not familiar with the curricular change process. At least 6 of the 9 participants from both campuses wanted to be better prepared and would have preferred researching, learning, and understanding what QSEN is and how QSEN would have impacted the curriculum and student learning prior to the start of the integration process. In Smith et al.'s (2007) survey assessment of QSEN integration in the curriculum, Smith et al. discussed differences in perspectives between program leaders such as deans, directors, and department chairs and faculty members regarding degree of QSEN integration in the nursing program curriculum and hypothesized that educational leaders were disconnected from their staff and out of touch with the realities of the curriculum.

In discussing effective system processes in learning organizations, Senge (2006) alluded to the discipline of a shared vision. Senge posited a shared vision as a goal that is shared and embraced by collective members of a team. Senge noted that people who share a common vision are bonded together by a common "aspiration" and desire to be "connected" (p. 192). When members of a team share a common goal, Senge claimed it adds synergy to the organizational goal, since each member's personal vision becomes an integral part of the whole. In this study, seven out of nine participants felt that the change process could have been improved if they had greater QSEN knowledge, had the opportunity to conduct some research, and actively engage in the integration change process. Senge posited that ongoing dialogue is needed (among stakeholders) to examine complex issues to obtain diverse perspectives and gain diverse insights, and group

discussions bring to light and help clarify personal assumptions that may be a potential barrier along the continuum of change. Joyner (2016) noted that communication gaps between leaders and staff could negatively influence staff members' attitudes in relation to how they perceive the reason for change and its impact on their teaching.

Finally, study findings confirm curricula gaps regarding safety and quality knowledge in nursing education, ongoing challenges implementing QSEN in the nursing program curriculum, the need for greater leadership support, and faculty's professional development in the QSEN competencies. In congruence with Benner (2001), as faculty transition from the novice to the expert phase in the scholarship of teaching and learning safety knowledge and skills, learners benefit from the experiences of educators who have become experts in the science of safety and quality. In addition, the need for broader support from leaders, greater access to resources for learning QSEN concepts including access to experts who are adept in QSEN knowledge and skills, will provide a foundation from which competency in QSEN concepts can be achieved.

Limitations of the Study

The limitations of the study are embedded in its design and were constrained by purposeful sampling of faculty members at two nursing colleges in the Northeast United States who were engaged in integrating QSEN into the nursing curriculum, classroom, clinical practicum, simulation, and nursing laboratory. Due to diversity in nursing programs' curricula across different nursing institutions, the resulting data may not be applicable to nursing programs that do not utilize in the QSEN curriculum. Data collection was obtained through direct, single, face-to-face interviews. I was familiar with

some of the study participants which may have resulted in socially acceptable responses, and the site of data collection for some participants such as on campus could have impacted their responses. Despite clarifying interview responses when deemed appropriate or when asked, participants may have refused to disclose data that they may have perceived as negative or sensitive. One participant refused to answer one question that she perceived that she “could not answer.” Being the sole investigator in this study, analysis, interpretation, and conclusions were based on my experience with the QSEN integration process, familiarity with the nursing education environment, and a background in nursing clinical practice.

As I collected the data, transcribed, and conducted the data analysis, I kept the purpose of the study in full view at all times, and purposed to maintain a neutral stance, and remained cognizant of my personal bias regarding the importance of learning quality and safety education. In addition, I adhered to all guidelines set forth by the Walden University and the interview protocol guidelines to minimize coercion, promote respect, and take an objective stance during data collection and analysis. I also corroborated the study findings with the results of the peer-reviewed studies I discussed in the literature review.

Recommendations for Further Research

The research findings in this study were limited to responses from nursing faculty members within a certain geographic region of the United States. Although quality and safety initiatives and standards have been widely advocated and implemented by the IOM, QSEN experts, governing, and accrediting agencies such as the Institute for Health

Care Improvement, Joint Commission, and the Agency for Health Care Research and Quality. QSEN has yet to permeate schools of nursing across all 50 states. Some gaps that I identified pertained to the role of leadership and their influence on the QSEN integration and implementation process. Future studies are needed that examine the role of leadership including how leaders communicate and execute the QSEN vision and roll out, and its subsequent impact on QSEN integration and faculty buy-in needs to be explored. In this research study, faculty wanted to be engaged in a greater way in the change decision making process and felt that the QSEN roll out would have resulted in greater success.

Regarding QSEN implementation, although the literature acknowledged that QSEN has been incorporated across schools of nursing, little is known regarding how faculty are interpreting and teaching the across different tiers in nursing education such as in the diploma, associated degree, and baccalaureate prepared programs. For example, in this study, faculty members had different perspectives regarding QSEN content and placement for different program levels. I would recommend studies that investigate and explore new and current QSEN curriculum guides and their effectiveness to standardize QSEN teaching across the curriculum perhaps utilizing the Barton et al. (2009) Delphi research that provided a guide regarding the placement of QSEN competencies across the curriculum. Additional exploratory research is needed at clinical learning sites as a basis for more targeted and increased learning and skill development in areas of teamwork and collaboration and informatics and improve collaboration between academia and practice. Expanded research at clinical sites could potentially elicit and develop practicing nurses'

skills in QSEN and enhance the learning environment, and the safety culture where nurse learning must occur.

Finally, exploring how QSEN's "attitudes" competency is interpreted, taught, and evaluated for each of the six QSEN competencies by nursing colleges needs further examination. Additionally, greater research is needed to assess and promote opportunities for faculty's professional development in QSEN competencies. Leadership support of faculty's professional development will impact QSEN integration as well as the quality of preparation for practice for future nurses.

Implications for Social Change

The perspectives of nurse faculty members as they integrated QSEN into their curriculum were explored. At the onset of QSEN integration, the challenges identified were gaps in communication, faculty's limited knowledge about QSEN that impacted curriculum development, and limited experiential learning opportunities for students' skill development. Faculty also desired greater resources and broader support for their professional development in QSEN competencies.

This study examined faculty perspectives at the initial roll out of QSEN and what factors influenced their responses and attitudes about the QSEN change process. At the onset of curricular change, dissatisfaction with the communication process may have impacted the curricular reform process since faculty members are the main stakeholders in creating and executing the curriculum framework and content. Effective teaching and learning are influenced by curricula content, structure, and instructional and evaluation methods (D'Eramo & Puckett, 2014). Additionally, effective communication strategies

may lead to greater transparency, engagement and collaboration, and fostering positive social interrelations may potentially result in greater faculty satisfaction and lower attrition rates during times of change that may be perceived as stressful. Senge (2006) noted that a learning (effective) organization engages its members in dialogue to include reflective thinking about complex issues and free flow of meaning between people. This activity generates greater insights that cannot be achieved individually as members are encouraged to share in a common vision toward a shared goal.

This study also confirmed gaps within the standard nursing curriculum related to structure and content. Although faculty members generally favored the QSEN learning model, they encountered challenges that impacted their ability to effectively integrate and implement QSEN. Nurse educators are guardians and important stakeholders in the discipline and practice of nursing and nursing education (Benner et al., 2010), and as faculty members in this study indicated, their knowledge and expertise are critical to effectively teach and model QSEN's knowledge, skills, and attitudes. In addition, faculty members interpret and deliver curricula content in the classroom where learners receive their grounding and foundational principles in nursing for lifelong practice. Strong training and development in QSEN principles, for example, directly impact on how future nurses are prepared to demonstrate safe and high performing professional practice.

Nurses are at the center of patient care at every point in the health care delivery system, and safe nursing practice is a public health concern. QSEN's broader and holistic approach to learning that includes knowledge of systems, informatics, and quality improvement has implications for nurse graduates at the onset of practice because basic

knowledge and experience about the health care environment can potentially decrease attrition rates and stress that new nurse graduates experience during the first 6 months of practice as they acclimate to their new clinical working environment. As new nurses understand the role of scientific evidence in practice, develop competence in safety concepts of identifying and preventing human and system related errors, and are challenged to demonstrate higher performance, higher quality care will result in decreased injuries, medication errors, infection rates, and patient deaths.

Conclusion

The integration of QSEN to reform nursing curricula received broad support by both faculty members and leaders within nursing education in the United States. Faculty, however, need broader support in obtaining and accessing learning resources to develop their knowledge and skills in QSEN, and administrative support is needed to develop collaboration between academia and practice to target meaningful learning experiences. With faculty's positive stance toward QSEN integration, support of these primary stakeholders is critical to sustain the vision of QSEN integration, reform nursing education, and transform how future nurses are prepared for higher standards of practice.

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Appendix A: Quality and Safety Education for Nurses (QSEN) Competencies

Competency	Definition
Patient-Centered Care	Recognize the patient or designee as the source of control and full partner in providing compassionate and coordinated care based on respect for patient's preferences, values, and needs.
Teamwork and Collaboration	Function effectively within nursing and inter-professional teams, fostering open communication, mutual respect, and shared decision-making to achieve quality patient care.
Evidence-Based Practice	Integrate best current evidence with clinical expertise and patient/family preferences and values for delivery of optimal health care.
Quality Improvement	Use data to monitor the outcomes of care processes and use improvement methods to design and test changes to continuously improve the quality and safety of health care systems.
Safety	Minimizes risk of harm to patients and providers through both system effectiveness and individual performance.
Informatics	Use information and technology to communicate, manage knowledge, mitigate error, and support decision making.

Adapted from: Cronenwett, et al., 2007

Appendix B: Interview Protocol

Your personal views, thoughts, and intellectual perspectives concerning the process of integrating quality and safety competencies into the nursing curriculum is kindly requested. The purpose of this information is to gather data from those who actively participated in the integration process to reform the nursing curriculum. The data that I collectively obtain from my interviews can potentially be very resourceful and essential to improve on future methods and processes used for future curricular reform.

Since there is potential for bias responses due to possible fear of reprisal, possible feelings of not being articulate enough, or positive enough, I can assure you that every opinion you provide *will not be judged in any manner* but will be highly valued and respected. Because this interview is simply to get your thoughts and perspectives, *there are no right or wrong answers*. Additionally, no responses you provide will negatively impact on my professional relationship or opinion about you. This project is also part of my dissertation requirement to obtain a doctoral degree in Adult Higher Education and all responses that you provide will be assigned numbers in order to keep all data confidential. Feel free to indicate whether you are not able to answer a question for any reason.

I have attached a table with definitions of the six QSEN competencies as a reference for you and cited the website for further clarity on the competencies: <http://qsen.org/competencies/pre-licensure-ksas> I have also provided a brief description of the event as a reminder as to what occurred. You are receiving the questions before the interview in to give you time to reflect on your views about the various questions.

1. From your perspective, tell me a bit about yourself as a faculty member at XXXXX.
2. Share your thoughts and perspectives concerning the decision to change the nursing curriculum objectives to incorporate quality and safety competencies?
3. What are your views regarding the QSEN competency curriculum compared to the old standard nursing curriculum?
4. What are your views regarding QSEN curriculum in relation to:
 - 4b. students' knowledge about safety and quality?
 - 4c. the impact on students' behaviors?
 - 4d. preparation for practice?
 - 4e. preparation for the NCLEX examination?
5. What are your views regarding faculty's role in curricular reform?
6. Tell me your views concerning how the QSEN meetings were organized and structured?
7. What factors, if any, could have or did contribute to the quality and outcome of the QSEN integration meetings?
8. Comment on faculty's knowledge and experience in QSEN concepts at the time of the QSEN integration meetings and designing new QSEN course objectives?
9. Was there anything that caught your attention or stood out to you during the group dialogue, brainstorming, and reflection that occurred during the QSEN integration meetings?

10. During the several weeks of integrating QSEN and revising the nursing course objectives, what was the most challenging aspect of the process for you?
11. During the several weeks of integrating QSEN and revising the nursing course objectives, what was the most positive (rewarding) if any – aspect of the process for you?
12. Considering the current content and volume of the nursing curriculum and the time from for program completion, what are your thoughts concerning having to change to a new curriculum?
13. At the time of the QSEN integration, how ready were you to learn and implement new QSEN competencies?
 - 13b. How do you feel now?

Appendix C: Data Analysis and Interpretation Examples

RQ#1: What are faculty perspectives regarding integrating quality and safety education for nurses (QSEN) as a curricular framework for a nursing program curriculum?

Codes	Themes
<p>“Well I think the hardest part was just trying to get it to mesh up to the curriculum to how its already set up...so, when you set up the syllabi and you are reading it, it has to reflect QSEN and I don’t think it had been done in the past.” “But, what we found was we had to change the wording of a lot of the descriptions in the subject so that it would show the incorporation of QSEN.” Harriet</p>	<p>QSEN integration is complex.</p>
<p>I think our process was arduous, tedious, similar to a process that I am not familiar with so, it included redoing a lot of the work I know that what we did go through will help us, when we do it again... but we literally did all of our course objectives and had to go back and re-do all of our course objectives. It was frustrating, but I think it was necessary - Shelly</p>	
<p>It was very tedious. We had to re-do all the curriculum, and it was a good thing because it improved it. But the process was very arduous...</p>	

RQ#2: What are faculty members’ attitudes concerning curricular change?

Codes	Themes
<p>A lot of the things we were doing already even though we weren’t explicitly talking about QSEN</p>	<p>QSEN is similar to nursing</p>

or addressing QSEN competency...
A lot of the things I think about was
included in the course already...
specifically, safety, specifically
patient-centered care, because
we are a culturally based curriculum” Shelly

We’ve always taught safety, we’ve
always taught sticking to evidence based
practice, but I think what QSEN does is
to makes you more aware. But it is not
that we were not teaching it,
but we are more aware.” Harriet

I think patient-centered care for
the students come a little easier
and even for us – because I think
is something we’ve been able
to really do a lot, and speak to a lot,
more so than the other parts.” Rhoda