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Wright's Competency Model and Quality and Safety Competencies

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This is to certify that the doctoral study by

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has been found to be complete and satisfactory in all respects, and
that any and all revisions required by
the review committee have been made.

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Abstract

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BSN, California State University, Fresno, 1996

Project Submitted in Partial Fulfillment of

the Requirements for the Degree of

Doctor of Nursing Practice

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Abstract

Competent nurses are instrumental in assuring that a patient receives safe patient care of the highest quality. Patient care that lacks quality places patients at risk of poor health outcomes and results in negative financial impacts for the organization. The purpose of this staff education project was to develop nurse competency education for a facility's competency program, which merged the Wright competency model with quality and safety education for nurses' competencies. The nurse competency staff education program was evaluated by the organization's stakeholders for inclusion in the competency program. The whole-part-whole model, Knowles's adult learning theory, and Lewin's change theory were used to guide this project. Pre- and posttest data were collected from 16 organization stakeholders, including nurse managers, directors, clinical nurse specialists, nursing professional development specialists, and preceptors, who participated in an in-person education session. Data were analyzed by calculating the mean test scores and calculating the percent change. Results indicated a 32% increase in knowledge from pre- to posttest. Findings supported implementation through the nursing departments and may furthermore support implementation across other healthcare disciplines within the organization. The project promoted social change by developing and providing education to improve nurses' knowledge regarding competent practice, ensuring safe and high quality nursing practice and supporting improved patient outcomes.

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Dedication

I would like to dedicate my work to all my nursing colleagues; it is important work that we all do that helps us to keep our patients safe and provide optimal outcomes. Although many times, we may feel forgotten, it is our work and passion that helps patients heal to their optimal health. I applaud each and every one of you.

Acknowledgments

First, I would like to thank God for getting me to this place. This would not be possible without my higher power.

Second, I would like to thank my husband, Kokia, and my daughter, Lauryn, for putting up with me through school. I would like to thank my parents for giving me the drive to always achieve more.

Third, I would like to thank all of my professors who have given me advice and feedback throughout my courses.

Finally, I would like to thank my chair and committee. Dr. Lewis has been instrumental in getting me here. As for my other committee members, Dr. Fink and Dr. Burton, I thank you for the time you have taken in reviewing and supporting my project.

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Section 1: Nature of the Project

Introduction

Healthcare quality and patient safety are the cornerstones of healthcare. In 1999, the Institute of Medicine called for healthcare to provide safer care and to report on quality measures. Since that report, many initiatives have been put in place to measure the quality and safety of medical facilities. Regulatory agencies, such as the Centers for Medicaid and Medicare Services (CMS), are using quality and safety data to determine a facility's merit (CMS, n.d.). Quality and safety data are reported as part of accreditation through The Joint Commission and Magnet designation (American Nurses Credentialing Center, n.d.; The Joint Commission, 2017).

Moreover, patients and their families are becoming more involved in the quality and safety of the care they receive (Agency for Healthcare Research and Quality, n.d.). With the focus on quality and safety, the Quality and Safety Education for Nurses (QSEN; 2018) project focuses on preparing future nurses to see quality and safety as core values in their nursing care. The QSEN project works with colleges and universities to focus on six core competencies that are similar to the IOM's competencies (Dolansky & Moore, 2013). The colleges and universities that funnel future nurses to the XYZ Hospital (a pseudonym) have embraced the QSEN model. To create a smoother transition for newly graduated nurses, XYZ Hospital uses the QSEN model of competency to mirror language that nurses find in school.

XYZ Hospital chose to model the competency philosophy of Donna Wright.

Wright is a registered nurse who specializes in competency and staff development and has worked with many healthcare organizations to develop comprehensive competency and staff development programs (Wright, 2005). Wright's (2005) philosophy is based on outcomes and allows nurses to be accountable for their practice. Merging the QSEN competencies and Wright's philosophy is new for the nursing department at XYZ Hospital. Incorporating the QSEN competencies with the Wright competency model brings the focus of competent nursing to quality and safety. Focusing on quality and safety influences the thoughts of nurses and ensures that quality and safety come first when caring for patients. In this DNP pproject, I focused on a staff education plan for the implementation of a nurse competency program for nurses at the XYZ Hospital.

Problem Statement

The setting for this doctoral project was a large, pediatric, academic medical center referred to as XYZ Hospital. XYZ Hospital's inpatient nursing competency program was written in a task-based manner. The program did not contain a baseline set of competencies for all nurses that work for the hospital; instead, each department or unit independently determined a set of core competencies for their area. As such, there was no baseline for all nurses to meet as part of the overall nursing department. This lack of an overall set of nurse competencies caused issues with nurses who float, either from their home unit or as part of the float team. Floating from the home unit to another unit causes safety issues if a nurse does not possess the correct competencies.

The current program had been in existence for more than 15 years and had not encompassed all aspects of the nursing process. Most of the current competencies only

addressed the skill portion of competency and did not include the knowledge needed or the associated attitude. This led to problems, such as performing a skill without knowing why the skill is being performed, performing skills on a patient that are contraindicated for the patient, and exclusion of the patient and family in planning care. From a quality and safety perspective, this competency program did not support high quality, safe nursing care.

XYZ Hospital began a competency transformation project in September 2017 with the expectation of full implementation by August 31, 2018. The hospital embraced the Wright competency model. Wright (2005) stated that competency assessment is to "evaluate individual performance, evaluate group performance, meet standards set by a regulatory agency, address problematic issues within the organization and enhance or replace performance review" (p. 2). Competency assessment evaluates the necessary skills needed for a job (Wright, 2005). The hospital leadership pushed to adopt this model because there is a strong emphasis on accountability for nurses across the organization. To support this need for an organization-wide set of competencies for nurses, the QSEN competencies were integrated to focus on the quality and safety aspects of nursing. The QSEN competencies align well with the IOM's recommendations to improve the quality of healthcare.

With the proposal of a change at the organization level, the educational plan for this project was comprehensive. A poor education plan can lead to poor compliance due to a lack of understanding of the program, resulting in a risk to healthcare quality and the safety of patient care. With poor quality and safety comes an increase in patient harm.

Ultimately, patient harm is what healthcare workers want to avoid. Introducing this competency project created a spotlight on quality and safety when caring for patients, something that was lacking at XYZ Hospital.

Purpose

The main goal of the DNP project was to develop an educational module on the merging of QSEN competencies and the Wright competency model into the XYZ Hospital's competency program. This program was much different than the current program because it uses the QSEN competencies and the objectives are to deliver educational information and resources that support the model. The education plan taught the end users about the QSEN project and the Wright competency model as well as how they are realized in actual practice. The XYZ Hospital's competency program added quality and safety as core values to nursing care and allowed the hospital to measure competency regarding the knowledge, skills, and attitude of a nurse.

The current competency program at XYZ Hospital was written with only the skill portion of the competency and is more like skills checklists. The current competency program did not include the knowledge or attitude assessments that the QSEN competencies support. For the new competency program to be successful, stakeholders needed to be educated on the purpose, goal, and process of the program. By developing the education plan, I sought to answer the practice question: After the education plan is implemented, will the pre- and posttest show an impact on the stakeholder's knowledge of the competency program?

Nature of the Doctoral Project

QSEN began as an answer to the IOM's call for an improvement in quality and safety in healthcare and a way for nursing programs to incorporate quality and safety into their curriculum in 2005 (Dolansky & Moore, 2013). As the students in nursing schools became evaluated on the QSEN competencies, they transitioned to practice at XYZ Hospital with competencies that were not similar. While the schools were trying to do a better job at preparing graduates for practice, there was a gap in how competence was being assessed in the practice setting (James, Patrician, & Miltner, 2017).

The IOM stated that all healthcare professionals should be able to deliver "patient-centered care through teamwork in collaboration, with teamwork and collaboration, with evidence-based care from continuous quality improvement, with a mindset for safety and employing informatics" (Sherwood & Zomorodi, 2014, p. 15). The QSEN Institute applied the same competencies, including patient- and familycentered care, teamwork, evidence-based practice, quality improvement, safety, and informatics (Sullivan, Hirst, & Cronenwett, 2009). QSEN's competencies were aimed at incorporating the goals from the IOM to improve the nursing practice (Dolansky & Moore, 2013). Nurses are on the frontline of care for patients and are often the last barrier between a patient and an error. It is important for nurses to have the IOM recommendations included in all aspects of their work from the beginnings in school throughout their career because only then can it be assumed that the health care system is grounded in quality and safety.

Approach or Procedural Steps

I grounded the educational plan project in the adult learning theory. Stakeholders provided feedback about the education plan in the form of a pre- and posttest survey. The information and teaching were delivered through a classroom format with discussion, games, and roleplaying and were housed in an electronic format so that even after the education and training are complete, the information will continue to be available. The electronic version also allowed for updates to the educational plan to occur regularly. The education plan used a train-the-trainer approach where the clinical nurse specialists (CNSs) and nurse educators were trained in the process. The CNSs and nurse educators then trained the preceptors in their respective units on an as needed basis.

I gathered data before the education plan about stakeholder's knowledge of both QSEN competencies and the Wright competency model through a simple, anonymous, online, nine-question survey. The survey was designed based on the educational objectives. I pretested this survey with a group of key stakeholders to assess its accuracy. The same questions were then asked of the participants after the education was completed. The survey determined whether the educational plan was successful.

Ethical Considerations

The survey was anonymous, did not use identifying data, and provided the information for a summative evaluation. The survey was voluntary, and no person was required to provide any information that they do not want to give. XYZ Hospital did not require Institutional Review Board (IRB) approval because there were no patients involved in the project. I obtained IRB approval from Walden University before carrying

out this project. This alleviated any concerns about the ethics of respect for people, beneficence, justice, and respect for communities.

Alignment

Providing education and the reasons why a change is being made was important for this change to be successful. The new competency system will bridge the gap of knowledge around QSEN competencies and how they can be incorporated in the practice setting. Successful change depends on the buy-in from both the stakeholders and the end-users. Providing them with the change and the appropriate education was the key to success. The education plan incorporated the adult learning theory and Lewin's change theory and was important in both the unfreezing and change stages because there was a need for information in those stages as to why the change is being made and what needs to be done to carry out the change.

<div align="center">

Significance

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The setting for the doctoral project was a large, pediatric, academic, medical center. The hospital has over 350 beds, and there are 60 associated clinics throughout the area. There are over 1,200 nurses that work in either ambulatory or inpatient areas. The educational plan encompassed teaching all participants, including preceptors, educational staff, and new hires. Newly hired nurses learned of the competency program in nursing orientation before going to the unit. Stakeholders, such as the CNSs and nurse educators, provided feedback on the learning plan to mitigate errors, such as missing information.

Quality and safety are not nursing specific measurements; other practice areas impact quality and safety. In healthcare, hospital-acquired conditions can be affected by anyone that comes into contact with the patient. A similar plan for competency that focuses on the knowledge, skills, and attitudes, with quality and safety for core values, can be developed for any healthcare practice area. The likely candidates would be physical or occupational therapists, child life therapists, or physicians. This plan for quality and safety can also apply to other areas, such as housekeeping, food services, and social workers. While they may not have the typical patient contact, they impact quality and safety when it comes to infection prevention and that can be written into their competencies.

Quality and safety around healthcare are at the forefront of every patient's mind. Medical centers post their quality and safety metrics on public websites for all the world to see and review. Regulatory agencies look to quality and safety initiatives and data to determine how qualified a hospital is to care for patients (CMS, n.d.). Agencies, such as CMS, determine payment for services based on quality and safety data and will not pay for services that are deemed to be caused by the hospital (CMS, n.d.). As such, hospitals need nurses who are well-versed in quality and safety and having competencies that are based on quality and safety is an important step toward that change.

The new competency program brought about social change in the way nurses' practice at XYZ Hospital. The introduction of the QSEN competencies brought the focus of a nurse's competence to the quality and safety of the patient. By merging the QSEN competencies and the Wright competency model, the competency program was focused

on outcomes that affect the quality and safety of patients. Rather than just assuming that a nurse can follow the steps of a procedure, the new competency plan assured that the nurse knows what to do, how to do it, and why they are doing it.

Summary

Quality and safety are the two hallmarks of exceptional patient care. A competency program grounded in quality and safety will provide nurses that have those hallmarks as their core values when working at XYZ Hospital. In this project, I focused on the education plan for the implementation of this competency program. In Section 2, I will focus on reviewing the literature and theories related to this education plan.

Section 2: Background and Context

Introduction

Quality and safety are the cornerstones of healthcare. In 1999, the IOM (1999) called for healthcare to provide safer care and to report on quality measures. Since that report, many initiatives have been put in place to measure the quality and safety of medical facilities. Regulatory agencies, such as the CMS, are using quality and safety data to determine a facility's merit (CMS, n.d.). Quality and safety data are reported as part of accreditation through The Joint Commission and Magnet designation program (The Joint Commission, 2017); moreover, patients and their families look to the Internet to find quality and safety data when choosing healthcare facilities.

With the focus on quality and safety, the QSEN (2018) project focuses on preparing future nurses to see quality and safety as core values in their nursing care. The QSEN project works with colleges and universities to focus on six core competencies that are similar to the IOM's competencies. The colleges and universities that funnel future nurses to the XYZ Hospital have embraced the QSEN model. To create a smoother transition for newly graduated nurses, XYZ Hospital uses the QSEN model of competency to mirror language that nurses find in school.

XYZ Hospital modeled the competency philosophy of Donna Wright. Wright's (2005) philosophy is based on outcomes and allows nurses to be accountable for their practice. Merging the QSEN competencies and the Wright philosophy was new for the nursing department at XYZ Hospital. I conducted this project to answer the following question: After implementing the education plan, will the pre- and posttest scores show

an impact on stakeholder's knowledge of the competency program. In this section, I will

cover the concepts, models, and theories used to establish the education plan, the

relevance to nursing, and the roles of the student and the team.

<div align="center">**Concepts, Models, and Theories**</div>

I built this project on the concepts of staff education, whole-part-whole (WPW)

model, and Knowles's adult learning theory. In this section, I will describe the concept,

models and theories used to develop this project.

Concept

Staff education is provided to support a nurse in learning new concepts,

equipment, or skills to ensure professional competence. The American Nurses

Association (ANA; n.d.) considers that it is a nurse's responsibility to maintain

professional competence. The ANA (2015) Code of Ethics for Nurses considers nurses

to be life-long learners because it is the responsibility of nurses to continue to be up-

todate on the current trends in patient care.

Model

The WPW learning model is a framework that educators can use for instructional

design (Knowles, et al., 2015). The model has three sections: the first whole, the parts,

and the second whole (Knowles, et al., 2015). The first whole indicates the introduction

of what is learned, the parts are the different concepts that make the whole and the

second whole is the summary of how it all fits together (Knowles, et al., 2015).

The first whole provides the information about the new concept by introducing

the information to the learners and beginning the formation of the framework in their

mind (Knowles et al., 2015). This part provides an introduction to the learner. This is an important part of the model because this will engage the learner and motivate them to learn (Knowles et al., 2015).

The parts begin after the first whole. The parts are the different segments that make up the whole (Knowles, et al., 2015). Often there are different parts of a staff education plan. Within this project, the whole is the staff education of the new competency program. The parts parcel out to include the definition of competency, the Wright model of ccompetency, and the QSEN. Each of these parts is essential to the whole competency program.

The second whole is putting it all together for the learner. The second whole connects all of the parts to form the whole again (Knowles et al., 2015). This second whole has connected the ideas for the learner so that the learner can form a complete understanding of the concept. Figure 1 illustrates the program in its entirety.
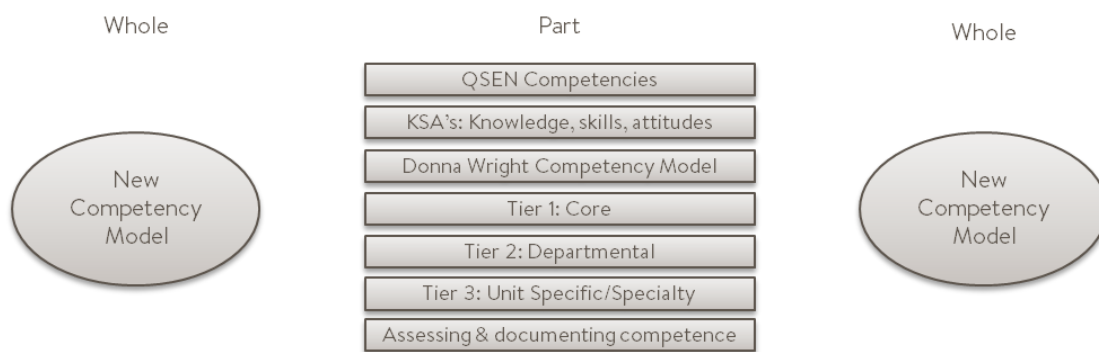

Figure 1. Whole-part-whole model: The content placed in the whole-part-whole model. From The adult learner: The definitive classic in Auld education and human resource development (8th ed.) by M. Knowles, E. Holton III, and R. Swanson, 2015, New York, NY: Routledge.

Theory

Knowles's (1984) adult learning ttheory is a learning theory based on six principles. The first principle is that adults need to know why they need to learn the new information (Knowles et al., 2015). The second principle is that adults are self-directed in their learning, and the third is that adults have a breadth of experience already as a resource (Knowles et al., 2015). The fourth principle is that adults are ready to learn when learning is needed, but do not want to learn if it is not immediately necessary (Knowles et al., 2015). The fifth principle is that adult learning occurs when the learning is pertinent to their competency, while the final principle is that adults are motivated to learn by their desire rather than it being a directive for an outside source (Knowles et al., 2015).

The adult learning theory is essential to keep in mind when developing education for adults. Adult learners will find it to be a waste of time when being taught something they already know (Kaufman, 2003). One way to alleviate this is to give background information as prework (Kaufman, 2003). This gives the learners who need it the opportunity to learn about the background information and brings all of the learners to the same starting point in the education.

Change can be a difficult process for anyone. Following Lewin's change theory provides a framework for moving through a change (Hussain et al., 2018). The first stage, unfreezing, is a way to find out what other options there are to a current process (Hussain, et al., 2018). This can be in the form of benchmarking or evaluating the current process (Hussain, et al., 2018). The second stage is changing, and during the changing

phase, new information is shared, processes are put into place, and the change is

implemented (Hussain, et al., 2018). The changing stage is the stage at which the staff

education project was delivered. The final stage is refreezing, and this is where the

change takes hold and becomes part of the culture (Hussain, et al., 2018).

The Wright (2005) competency model is based on three elements of success. The

first element is that competencies are identified by a group of unit leadership and staff

(Wright, 2005). They should reflect the changing nature of the actual work that is

occurring (Wright, 2005). The second element is that the verification methods should be

developed with the employee in mind (Wright, 2005). Wright identified 11 verification

methods, stating that each competency should have two or three methods of verification.

The final element is that there is a culture for success (Wright, 2005). Leadership should

assure that competencies are designed to support the organizational mission as well as

providing support to the employees to ensure their success (Wright, 2005).

Relevance to Nursing Practice

QSEN began as an answer to the IOM's call for an improvement in quality and

safety in healthcare and a way for nursing programs to incorporate quality and safety in

curricula in 2005 (Dolansky & Moore, 2013). As the students in nursing schools became

evaluated on the QSEN competencies, they may transition to practice with competencies

that were not similar. While the schools were trying to do a better job of preparing

graduates for practice, there was a gap in how competence was being assessed in the

practice setting (Dolansky & Moore, 2013).

As they called for a change, the IOM stated that all healthcare professionals should be able to deliver "patient-centered care through teamwork in collaboration, with teamwork and collaboration, with evidence-based care from continuous quality improvement, with a mindset for safety and employing informatics" (Sherwood & Zomorodi, 2014, p. 15). The QSEN Institute applied the same competencies, including patient- and family-centered care, teamwork, evidence-based practice, quality improvement, safety, and informatics (Sullivan et al., 2009). QSEN's competencies were aimed at incorporating the goals from the IOM to improve the nursing practice (Sullivan, et al., 2009). Nurses are at the forefront of care for patients and are often the last barrier between a patient and an error. It is important for nurses to have the IOM recommendations included in all aspects of their work from the beginnings in school throughout their career because only then can it be assumed that the health care system is grounded in quality and safety.

While embedding the QSEN competencies into the program, XYZ Hospital used the Wright competency model. Competency assessment evaluates the necessary skills needed for a job (Wright, 2005). This model has been strongly supported by hospital leadership. In conjunction with this model, the QSEN competencies are integrated to focus on the quality and safety aspects of nursing. The QSEN competencies align well with the IOM's recommendations to improve the quality of healthcare. Although the QSEN competencies are written as competencies for a postbaccalaureate nurse or postgraduate nurse at graduation, I incorporated the competency themes into this project.

With such an encompassing change, the educational plan for this project needed to be comprehensive. A poor education plan can lead to poor compliance and risk the quality and safety of patient care due to not fully understanding of the program. With poor quality and safety comes an increase in patient harm, and ultimately, patient harm is what healthcare workers want to avoid (Wolf & Hughes, 2008).

Utilizing Knowles's adult learning theory provides a framework for adults to learn information that is immediately useful to them (Gatti-Petito et al., 2013). The adult learning theory allows adult learners to bring their prior experience as a resource for learning as well as it contributes to their preexisting set of beliefs (Curran, 2014). The adult learning theory is based on the experience of the learner and relies on the learner to absorb the knowledge that is provided (Knowles et al., 2015). Adults are open to learning when what is taught is relevant to their practice and learning is collaborative between the teacher and the learner (Curran, 2014).

The new competency program I developed for this project filled the gap of quality and safety outcomes being the focus of a nurse's competence. The Joint Commission's (2018) vision statement is "all people always experience the safest, highest quality, best value health care across all settings" (p. 1). With a focus on the QSEN competencies, the new competency program supports the Joint Commission's vision statement and will influence the nurse's practice of providing safe, high-quality care. The added focus on quality and safety also supports the CMS standards. The increased focus on quality and safety allows the nurse to influence the standards with the care they are providing.

Patients and families will receive the most benefit from the program by the nurses'

implementation of focusing on quality and safety because the patients are the ones who

will reap the rewards of receiving care that is safe and of high quality. The competency

program will shift the nurses' focus on patient care to that of quality and safety outcomes.

Local Background and Context

The setting for this doctoral project was a large, pediatric, academic, medical

center referred to as XYZ Hospital. The hospital has over 350 beds, and there are 60

associated clinics throughout the area. There are over 1,200 nurses that work in either

ambulatory or inpatient areas. XYZ Hospital's inpatient nursing competency program is

written in a task-based manner. The program did not contain a baseline set of

competencies for all nurses that begin working for the hospital; instead, each department

or unit independently determined a set of core competencies for their area. There was no

baseline for all nurses to meet as part of the nursing department because each department

determines what the list of competencies will be. The lack of a standardized set of core

competencies has caused safety issues with nurses who float, either from their home unit

or as part of the float team because they may not have the core competencies for the unit

they are floating to. The current program was in existence for over 15 years and did not

follow a standard format to encompass the knowledge, skills, and attitudes needed for the

competency. Most of the current competencies only addressed the skill portion of a

competency and did not include the knowledge needed or the associated attitude. This

can lead to problems, such as performing a skill without knowing why the skill is being

performed, performing skills on a patient that is contraindicated for the patient, and

exclusion of the patient and family in planning care. From a quality and safety

perspective, the current competency program did not support high quality, safe nursing

care.

XYZ Hospital began a competency transformation project in September 2017

with the expectation of full implementation by August 31, 2018. The hospital embraced

the Wright competency model. Also, as mentioned previously, the QSEN competencies

also align well with the Joint Commission and CMS as the focus of these two

organizations is safe, high-quality healthcare (Centers for Medicare and Medicaid

Services, n.d.; The Joint Commission, 2018).

Definitions

Clinical nurse specialist (CNS): A nurse with advanced education and training in

a specific area who is considered a clinical expert (National Association of Clinical Nurse

Specialists, 2018).

Competence: Knowledge, skills, and attitudes required to do a specific job in the

job setting.

Electronic format: Online format available at all times where education and

information are available at the point of need.

Unit-based educator: Nursing educator who is primarily based on a specific unit.

Role of the DNP Student

The role of the DNP student was to oversee and coordinate the project. As an

employee of the hospital for over 15 years, I have been dismayed by the current

competency program which changed minimally in the last several years. Early in my

doctoral program, I knew I wanted to develop the competency project, and it has evolved

since then. As an educator, much of the education I have provided is around the quality

of care and safety of the care provided to our patients. The education plan will assist in

assuring the success of the program.

At about the time I started this program, there was a leadership change in the

hospital with a new chief nursing officer and her team. This team was looking into all

aspects of nursing care, and it was at this time, I was able to suggest a new method of

competency assessment. I started the research on both Wright as well as QSEN. Once I

got an agreement with the executives on the model, I was given the green light to build a

team and develop the plan.

There can be potential biases as I agree with Wright's method of outcomes-based

competency. Competencies based in outcomes give nurses a reason to do them (Wright,

2005). This also plays to the adult learning theory as there needs to be a reason for nurses

to learn something new (Knowles et al., 2015). Because both of these speak to me in a

way that I appreciate, I may have neglectful to look for other solutions. Having a team

does help me in confirming that this method will take all elements into account.

Role of the Project Team

The project team includes the director of professional development and education

(PDE) and three centralized nursing professional development specialists (NPDS). The

overall education plan, including the survey, was approved by the director of PDE. The

project was evaluated at every step by the project team to assure we are meeting the

overall objectives of the education plan. Using a method of analysis, design,

development, implementation, and evaluation (ADDIE), formative evaluation is vital at every step, and summative evaluation was completed after the education process (Kurt, 2018). The project team was involved in every step to evaluate the education plan.

The project team participated in the evaluation throughout the development of the education plan using the ADDIE method. The project team was given an overview of the staff education plan as it was developed. The project team was able to evaluate the education plan including the pre- and posttest using an anonymous questionnaire Upon the receipt of the anonymous feedback, changes were made to the plan and redelivered to the project team. The second round of feedback was solicited anonymously to assure that the content was valid and usable.

Summary

New initiatives and practice changes require some education. As a new method of writing and evaluating competencies, an education plan is imperative for all involved. The use of theory and method ensure that the education plan is thorough and complete so that success can be achieved. Although there can be roadblocks, the theory and model continue to direct the education plan to the ultimate goal. In Section 3, I will focus on how data will be collected and analyzed for the education plan.

Section 3: Collection and Analysis of Evidence

Introduction

This project provides an education plan to introduce a new competency program for XYZ Hospital. The education plan was needed to introduce the new program to those

who will be using it. In the previous sections, I discussed why the education plan was needed and the impact it will have on the end-users. In Section 3, I will discuss the collection and analysis of evidence as it related to the education plan.

Practice-Focused Question

In this project, I used a single group, pre- and posttest design to answer the following project question: After implementing the education plan, will the pre- and posttest scores show an impact on stakeholder's knowledge of the competency program?

Sources of Evidence

I used the pre- and posttest design to assess the learner's knowledge before and after the intervention to determine whether there was any impact on their knowledge. An increase in knowledge after the educational intervention was a positive result. However, a decrease in knowledge would have indicated that the educational intervention did not have the impact that was desired.

To determine the validity of the test, I gave it to a small group of key stakeholders. The stakeholders completed the test, and then the answers were analyzed. My analysis included determining if the questions were answered correctly, whether the questions answered the objectives, and if any questions were missing. Pretesting a newly developed questionnaire lends to determining the validity of the questionnaire (Kirby et al., 2017).

The pre- and posttest consisted of 14 questions, five of which were demographic and nine of which tested the participants' knowledge about competence, Wright's competency model, and the QSEN competencies. I administered the pretest administered

directly before the education to assess the participants' current knowledge. Both the pre- and posttest were administered through an online tool that was accessible through any mobile device. For those that did not have a mobile device with them, I made mobile devices available for them to use. The posttest was administered immediately after the education through the same platform to keep the sample the same.

In addition to the pre- and posttest evidence, I gathered demographic evidence from the participants. The pre- and posttest data were used to show the actual impact of the educational plan. The questions on both of the tests were the same to show whether there was an impact on their knowledge. The purpose of gathering demographic data was two-fold. Demographic data provide a snapshot of the sample's representation (Grove, Burns, & Gray, 2013). I also used the demographics because they provided information on why or why not the education plan was impactful. Demographic data can also show bias. For instance, if the pre- and posttest data showed a statistically significant impact, but the demographics showed that the sample was White women aged 45 to 55 years old, then the significance can only be applied to those that fit that demographic identity. All of the data collected were used to determine the impact of the education.

I collected evidence from a known group of participants that were selected based on a few criteria. The first criteria were RNs that were unit-based NPDS and CNSs. These participants will be the trainers on the units once they receive the training. In addition to them, there will be up to 30 preceptors that have been chosen by their leadership teams to precept a group of 15 new graduate nurses who will be entering the Nurse Residency Program in the spring. These preceptors will be the first to use the new

competency program to assess the new graduate nurses and their progression through their orientation. Therefore, these groups needed to understand and be able to effectively use the new competency program.

I developed the pre- and posttest based on the QSEN competencies and the Wright competency model. Questions were created from the information that was in the educational plan (see Appendix A) The test was multiple choice with one correct answer per question. Answers were similar in length so there was not one long answer with three short answers to suggest that the long answer was the correct answer. The pre- and posttest was given to the project team who tested it as part of the evaluation process of the staff education plan.

While developing and carrying out the project, I provided ethical considerations through the Walden University IRB process. The study site agreed to allow me to collect data using anonymous questionnaires of its staff and did not require additional IRB approval from the site because the project did not involve talking with patients or patients' families. Furthermore, all participants used a standard consent that allowed them to decide whether to participate (see Appendix B). I kept all questionnaires anonymous and gathered them electronically to maintain participant confidentiality. Although the staff education plan is mandatory, participants could opt out of the pre- and posttest at any time

Analysis and Synthesis

I analyzed the pre- and posttest data after they were collected. The data collection tool demonstrated whether the education plan had an impact on the participant's

knowledge. If the education plan was successful, the posttest would have a higher score than the pretest. If there is no impact on knowledge, the collection tool would have the demographic data which can be used to determine whether demographics had any role in the outcome (Grove et al., 2013).

Using Microsoft Excel, I created graphs to show the impact the education had on the pre- and posttest scores. With the survey software, the data were collected and analyzed both individually and cumulatively. The survey software also had a feature with which to determine question bias, if there is any. Depending on the overall results of test scores, I was able to look at individual question scores as well in the software. My sstatistical analysis of the pre- and posttest scores using a *t* test showed whether the difference in score wass significant. This process provided a well-rounded analysis of the data.

The evidence remained confidential with no participant names included anywhere in the data or project. There was also no evidence provided from the hhospital itself without all identifiers having been removed. To avoid missing data, I built the survey so that the learner had to answer all the questions before submitting it. Should have anyone been able to answer only part of the survey, the answers from that participant would have been removed.

Summary

I collected the data for this project from an anonymous pre- and posttest survey. Participants were given a choice to participate or not in the pre- and posttest through a standardized form of consent. The data were analyzed to show whether there was an

impact on the participants' knowledge and if that impact was significant. Data from the survey remained anonymous because there were no indicators of who took the survey. Data surrounding the hospital remained confidential because all hospital identifiers were removed. In the next section, I will discuss the actual findings and provide further recommendations.

Section 4: Findings and Recommendations

Introduction

XYZ hospital had a task-based competency system that was not rooted in quality or safety outcomes. The competency program was changing to utilize the Wright model of competency and incorporate the QSEN competencies. The purpose of this DNP project was to create a detailed education plan to increase the knowledge of the learners about the new competency program. The practice-focused question used to facilitate this project was as follows: After the education plan is implemented, will the pre- and posttest show an impact on the stakeholder's knowledge of the competency program?

I administered a nine-question test before and after the education session (see Appendix B). The nine questions tested participants' knowledge about the Wright competency model and the QSEN competencies. The questions were formatted as true/false and multiple-choice questions. I administered the test via an electronic survey tool, and all questions were set as mandatory to answer.

I analyzed the test data using a two-sample t test with a p value set at 0.05. The sample size was 16 RNs working in the facility in the role of manager, CNS, or preceptor. I will discuss the data analysis and synthesis of findings in the following subsections.

Findings and Implications

Sixteen nurses completed the survey prior to the education class via the electronic survey tool. The class was presented on several different days and times over a 2-week period to accommodate various work schedules. The posttest was given after the

education was delivered. I compared the pre- and posttest results using a *t* test with the *p*

value set at ⬜ 0.05 for all analyses. SPSS was used to complete the analysis.

The results of the pre- and posttests showed statistical significance in that

participants' knowledge increased after the education was delivered. The pretest mean

score was 74.56 and the posttest mean score was 98.61. The mean score of knowledge

shows an increase of 24 points after the education was delivered. The test scores

increased by 32%.

Unanticipated Findings

The participants were 81% female, 81% were in the age range of 35 to 44 years

old or higher, and 75% had a baccalaureate level education or higher. From this

demographic data, I inferred that these nurses graduated 10 to 20 years ago and would

have very little exposure to the QSEN competencies and Wright's model of competency.

Upon comparison of results, the nurses that held a master's or doctoral degree were those

who scored the highest on both the pre- and posttest.

Implications

Upon completion of this project, the education plan will remain the primary

education method as the project continues to roll out. As this is a change in culture, there

will be added methodologies as well to meet the needs of multiple learners with different

schedules, learning styles, and needs. Additional methods will include a performance

support website, an online module, and continued in-person classes. The content will be

worked into existing preceptor classes rather than being a stand-alone class to continue

the in-person support.

This change in culture will support the facility's mission to provide safe, quality care. Nurses' competence will be reflected in safety and quality outcomes, which provide better patient outcomes. Fiscally, a facility that provides safe, competent care will have less fines and will receive higher third-payer reimbursements, increasing their revenue. High quality care that is safe for patients leads to better outcomes for the community as well making the results of this project a positive social change.

Recommendations

Given the statistically significant positive results, I recommend this staff education plan should continue. To reach a larger audience, it is recommended that the education material is delivered in many ways. With the number of learners this change in culture needs to reach, providing many modalities through which this information can be obtained would help spread the information. The objectives and content should remain the same due to the increase in the mean of the knowledge questions from the pre- to the posttest.

I recommend that the educational plan should not be the end of this project. This change in culture should be modeled and discussed at all levels of the facility. Continuing to speak the same language will demonstrate the facility's commitment to social change. Once this change in culture has made the shift in nursing, it would be prudent to carry it forward to all patient care service departments. This wider implementation would carry the message of quality and safe care to the community.

Contribution of the Doctoral Project Team

With the assistance of the project team, I was able to collect and analyze the pre-
and posttest data to provide recommendations for change based on the project results.
Throughout the project, the project team was available to clarify and modify the plan as
needed. In addition, the project team validated the recommendations that were presented.
This project has laid the groundwork to continue the change in culture around
competency.

Strengths and Limitations of the Project

While the number of participants was low in this project, those that participated
were eager to do so. The resources in planning and implementing the project were
readily available. However, there were no fiscal resources available, which had a part in
the limited number of resources. The nonexempt staff were not paid to take part in the
educational offering, which limited the amount of bedside staff that attended. Going
forward, placing this content in the mandatory preceptor class will assure that at least
preceptors who will be validating competency receive the information.

Section 5: Dissemination Plan

The results and recommendations of the project are relevant to all levels of patient
care services staff at the facility. Plans to disseminate this information to the
stakeholders have been put in place. The final report will be available in electronic and
hard-copy formats. In addition, this information will be presented to the different levels
of nursing management, which will include the vice president of patient care services.

I will revise the final paper to send to nursing education publications for consideration. I also plan on writing abstracts to present this information in either podium or poster presentations at several national and international conferences. This will help to disseminate the information to other facilities.

Analysis of Self

This DNP project has taken me in a direction that I did not anticipate. I started this program to show my daughter that she can be anything she wants and to make my parents proud of what I have become. I have grown in my professional career and have earned the respect of many people outside of just the nursing department. As I have been working on this project, other doors have opened, such as two requests to be a guest speaker at regional meetings for an international organization.

I obtained my master's in nursing in education in 2012 from Walden University, and I returned in 2016 to begin the process for my DNP. Over the past 7 years, I have worked as a nursing professional development specialist. As I completed this project, my focus shifted to academia. I have been at my current place of employment for the majority of my career, and one of my goals was to retire from there. As I have progressed through this journey, I have realized the importance of nursing education from the beginning and desire to make my mark in academia.

Throughout this program, my DNP instructors and mentors have taught me the value of education and how to be inspirational in our work. As a DNP graduate, my role is to further our profession by advocating for higher education and becoming more

involved in policy making for nursing. I will seek out opportunities to be more active at

the state level in policy making to further my involvement.

Summary

My goal with this project was to provide comprehensive education for

stakeholders regarding a new competency program that would result in a change in

culture. The creation and implementation of this education plan has provided key

stakeholders with an increase in knowledge in the new competency program. In turn,

nurses are changing their practice to focus on safe, competent care centered on patient

outcomes. In the end, this change will provide positive fiscal effects for the facility in

terms of reimbursement and cost savings due to fewer quality issues. Overall, the

community will benefit from a facility with high positive outcomes.

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Appendix A: Staff Education Plan

BEHAVIORAL OBJECTIVES By the end of this class, the Student will be able to:	CONTENT (TOPICS) Provide description/outline of content to be presented	AGENDA TIMEFRAME HHMM- HHMM	PRESENTER NAME & CREDENTIAL Faculty per topic area	TEACHING METHODS Check all that apply
	Welcome and Introductions	0800 – 0815	Staci Shanks, MSN, RN-BC	
1. Describe competency assessment and validation.	Initial Competency Assessment and Validation: What does this mean?	0815- 0845	Staci Shanks, MSN, RN-BC	☒Lecture ☐ Video & Audio ☒ Discussion ☐ Case Studies ☐ Role Play ☐ Simulations ☐ Demonstration ☐ Games ☐ Self-Learning Modules ☐ Computer Applications ☐ E-learning via Intranet or Internet

2. Correlate the six QSEN competencies with bedside practice scenarios.	Quality and Safety Education in Nursing: Translating the QSEN competencies into practice.	0845-0930	Staci Shanks, MSN, RN-BC	☒Lecture ☐ Video & Audio ☒ Discussion ☐ Case Studies ☒ Role Play ☐ Simulations ☐ Demonstration ☐ Games ☐ Self-Learning Modules ☐ Computer Applications ☐ E-learning via
				Intranet or Internet

3. Describe the Tier One Clinical Nurse competency process. 4. Demonstrate where to find the Tier one competencies. 5. Demonstrate the electronic documentation of validation.	Overview of Tier One Clinical Nurse Competencies: Structure, Process, and Tools for Success	0930-1015	Staci Shanks, MSN, RN-BC	☐Lecture ☐ Video & Audio ☒ Discussion ☐ Case Studies ☐ Role Play ☐ Simulations ☒ Demonstration ☐ Games ☐ Self-Learning Modules ☒ Computer Applications ☐ E-learning via Intranet or Internet
6. Describe the 11 competency validation methods. 7. Match at least seven competencies with the appropriate validation method.	Competency Validation Methods	1015-1100	Staci Shanks, MSN, RN-BC	☐Lecture ☐ Video & Audio ☒ Discussion ☐ Case Studies ☐ Role Play ☐ Simulations ☒ Demonstration ☐ Games ☐ Self-Learning Modules
				☐ Computer Applications ☐ E-learning via Intranet or Internet

8. Contrast the roles and responsibilities of at least two of the stakeholders.	Roles and Responsibilities: Manager, CNS, Educator, Preceptor, Clinical Nurse	1100-1130	Staci Shanks, MSN, RN-BC	☐Lecture ☐ Video & Audio ☒ Discussion ☐ Case Studies ☐ Role Play ☐ Simulations ☒ Demonstration ☐ Games ☐ Self-Learning Modules ☐ Computer Applications ☐ E-learning via Intranet or Internet
	Wrap up	1130-1200	Staci Shanks, MSN, RN-BC	

Appendix B: Questions and Answers for Pre- and Posttest

1. Competency assessment is an expected and measurable level of nursing performance that integrates knowledge, skills, abilities, and judgement, based on established scientific knowledge, and expectations for nursing practice.
    a. True
    b. False
2. There can be more than one way to verify a specific competency.
    a. True
    b. False
3. Donna Wright's Competency Assessment Model is a collaborative process in which competencies are identified and reflect the dynamic nature of the work.
    a. True
    b. False
4. The QSEN Competencies include:
    a. Patient-Centered Care
    b. Teamwork and Collaboration

    c.   Evidence-Based Practice

    d.   Quality Improvement

    e.   Safety

    f.   Informatics

    g.   All of the above 5. KSA's are:

    a. Knowledge, Skills, and Abilities

    b. Knowledge, Skills, and Attitudes

    c. Knowledge, Service, and Attitude

    d. Knowledge, Stance, and Abilities.

6. Tier 1 competencies are specialty competencies
   a. True
   b. False

7. Validation methods include:
   a. Post-tests
   b. Return demonstration
   c. Observation of daily work
   d. Case studies
   e. Exemplars
   f. Peer Reviews
   g. Self-assessment
   h. Discussion groups
   i. Mock events
   j. QI monitors
   k. Presentations
   l. All of the above

8. Which method would be best to validate how a nurse performs in a Code Blue emergency response?
   a. Exemplar
   b. Mock event
   c. Case Study

9. Ultimately, the _____ is responsible for the competency of the bedside nurse.
   a. Bedside nurse
   b. CNO
   c. CNS
   d. Manager
   e. NPDS/Educator

Answers

1. a 2. a
3. a
4. g 5. b
6. b
7. l
8. b
9. d