

Quality and Safety Education for Nurses

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Introduction

Quality and Safety Education for Nurses (QSEN) organizes nursing education around six competencies: patient-centered care, teamwork and collaboration, evidence-based practice, quality improvement, safety, and informatics. The competencies are not separate tasks completed once. They form an integrated way of thinking and acting so that nurses can reduce preventable harm while respecting the needs and values of each patient. (Quality and Safety Education for Nurses Institute)

A patient admitted with [chronic obstructive pulmonary disease](#) (COPD) demonstrates how the framework operates in practice. COPD can involve breathlessness, cough, sputum, exercise limitation, anxiety, exacerbations, and complex treatment. Safe care requires assessment, oxygen and medication management, communication across disciplines, attention to smoking and environmental exposure, inhaler education, discharge planning, and follow-up. QSEN helps connect these activities to observable knowledge, skills, and attitudes.

Patient-Centered Care

Patient-centered care recognizes the patient or designee as a full partner in coordinated and compassionate care. The nurse begins by asking what matters to the patient: relief of breathlessness, ability to sleep, returning home, maintaining independence, understanding inhalers, or reducing fear. Clinical priorities remain essential, but they are discussed rather than imposed without explanation.

For a patient with COPD, assessment includes respiratory rate and effort, oxygen saturation interpreted in context, breath sounds, mental status, sputum, pain, activity tolerance, nutrition, anxiety, and previous exacerbations. The nurse asks about usual oxygen use, inhalers, affordability, home environment, smoking or occupational exposure, transportation, health literacy, and caregiver support.

Cultural humility means asking about beliefs and preferences without assuming that ethnicity predicts treatment choices. Qualified interpreters should be used when needed. Teach-back allows the patient to explain in their own words how to use an inhaler, when to seek help, and how medications differ. Patient-centered care also protects dignity during breathlessness, when dependence and panic can make a person feel powerless.

Teamwork and Collaboration

COPD care can involve nurses, physicians, respiratory therapists, pharmacists, physical and occupational therapists, dietitians, social workers, case managers, and primary-care or pulmonary teams. Collaboration is more than referring the patient to each profession. The team needs a shared plan, clear roles, reliable handoffs, and mechanisms for resolving disagreement.

Structured communication tools can reduce omission. A nurse reporting worsening respiratory distress should communicate the current condition, relevant background, assessment, and requested response. During rounds, the patient should be included when possible. Medication reconciliation requires coordination because duplicate inhalers, incorrect devices, sedatives, or interactions can create risk.

Psychological safety within the team is crucial. A student or junior nurse must be able to question an oxygen order, identify a mismatch in the chart, or report deterioration without fear of humiliation. Respectful escalation is a safety behavior, not insubordination.

Evidence-Based Practice

Evidence-based practice integrates the best available research with clinical expertise and patient preferences. It does not mean applying one guideline mechanically. Nurses must know the purpose, benefits, risks, and limits of interventions and recognize when the patient differs from a typical study population. (Quality and Safety Education for Nurses Institute)

For COPD, evidence informs inhaled bronchodilator therapy, systemic corticosteroids during selected exacerbations, controlled oxygen administration, pulmonary rehabilitation, vaccination, smoking cessation, and discharge follow-up. Antibiotics are appropriate in particular clinical circumstances rather than for every exacerbation. Oxygen targets and escalation should follow the patient's condition and local protocol.

The nurse evaluates the quality and relevance of sources. A commercial website or unsourced summary should not outweigh current guideline, systematic-review, or institutional evidence. When policy differs from emerging evidence, the nurse should use established channels to request review rather than quietly ignore policy.

Quality Improvement

Quality improvement uses data to change local systems. Research asks what is generally true; quality improvement asks how to make care in this setting more reliable. A COPD unit might examine thirty-day readmissions, delayed bronchodilator treatment, inhaler-technique documentation, vaccination

assessment, smoking-cessation referral, or completion of discharge follow-up.

A team could use a Plan-Do-Study-Act cycle. It might test a respiratory-discharge checklist on one unit, measure completion and patient understanding, review unintended burdens, and revise the process before wider adoption. Data should be stratified when possible to determine whether language, race, insurance, rural residence, or disability is associated with unequal outcomes.

Improvement is not achieved by blaming individual nurses for every failure. If essential equipment is difficult to locate or the electronic record hides important information, redesigning the system may be more effective than repeated reminders.

Safety

Safety minimizes risk to patients and providers through both individual performance and reliable systems. COPD care includes risks related to respiratory deterioration, medication error, oxygen equipment, falls, infection, delirium, aspiration, and transitions between settings.

The nurse must recognize urgent changes such as increasing work of breathing, altered mental status, exhaustion, cyanosis, hemodynamic instability, or a “silent” chest. Oxygen should be treated as a medication with a prescribed target and ongoing reassessment. The goal is to correct hypoxemia while avoiding both undertreatment and inappropriate administration. Patients using oxygen need fire-safety education, especially regarding smoking and open flames. (Cronenwett et al.)

Medication safety includes the right drug, dose, route, time, indication, response, and documentation. Inhaler devices require correct technique; a prescription alone does not ensure delivery. High-risk transitions require reconciliation and confirmation that the patient can obtain and use the medications.

Informatics

Informatics uses information and technology to communicate, manage knowledge, reduce error, and support decisions. The electronic health record can display oxygen trends, arterial or venous blood-gas results, respiratory assessments, medication administration, allergies, prior cultures, imaging, and discharge needs. Templates should support clinical reasoning rather than encourage copied text.

Decision support can warn about duplicate therapy, renal dosing, interactions, or overdue reassessment. Too many low-value alerts produce fatigue. Nurses should participate in system design because they understand workflow and can identify when data fields create delay or conceal deterioration.

Telemonitoring and predictive analytics may help identify some high-risk patients, but artificial

intelligence is not independently responsible for care. Models can produce false alarms, miss atypical presentations, or perform differently across populations. Human review, validation, privacy protection, and clear accountability are necessary.

Applying All Six Competencies to a COPD Exacerbation

Consider a patient admitted with increased breathlessness and sputum. Patient-centered care begins with symptoms, goals, preferences, and communication needs. Safety requires rapid assessment, appropriate escalation, controlled oxygen, medication verification, and monitoring. Teamwork brings respiratory therapy, pharmacy, medical staff, and discharge services into one plan. Evidence-based practice guides treatment and education. Informatics provides trends and supports communication. Quality improvement asks whether the unit consistently delivers these elements and whether outcomes differ across patient groups.

The competencies function simultaneously. A technically correct treatment can still fail if the patient cannot afford the inhaler, misunderstands the device, lacks electricity for equipment, or cannot attend follow-up. Quality is the reliability with which the system converts evidence into care the patient can actually use.

Education and Discharge Planning

Discharge begins at admission. The nurse assesses baseline function, home support, equipment, pharmacy access, and prior barriers. Education should be delivered in short segments because breathlessness and fatigue reduce concentration. Demonstration and teach-back are more useful than handing the patient a dense brochure. (Cronenwett et al.)

The plan should clarify maintenance and rescue medicines, inhaler technique, oxygen instructions, activity, nutrition, smoking cessation, vaccination, warning signs, and follow-up. The patient should know whom to contact and what to do if symptoms worsen. Written material must match language and literacy needs.

Education and Clinical Evaluation

QSEN education should translate abstract competencies into observable practice. Students can be assessed through simulation, clinical observation, chart review, case analysis, and reflection. Evaluation criteria might include inviting the patient into decisions, using a structured handoff, locating and applying a guideline, identifying a process defect, reporting a safety concern, and documenting accurately in the electronic record. Faculty should distinguish a knowledge gap from a

system barrier and provide feedback that specifies the behavior to improve.

Simulation is especially useful for rare or rapidly deteriorating respiratory events. Debriefing should examine clinical decisions, communication, workload, assumptions, and emotional response. The purpose is not to humiliate the learner but to strengthen future performance and the willingness to speak up.

Ethics and Equity

QSEN includes attitudes as well as technical skills. Nurses should value the patient's knowledge, respect team members, remain willing to question practice, and accept responsibility for learning. Equity is embedded in quality: a system is not safe if reliable care is available only to patients with money, English proficiency, transportation, or family support.

Nurses can identify barriers and advocate for social work, medication assistance, home services, or accessible equipment. They should also avoid stigmatizing patients who smoke or have repeated admissions. Behavior change is difficult, and respectful support is more effective than blame.

Quality Indicators for COPD Nursing Care

A unit can translate QSEN into measurable indicators. Examples include documented inhaler teach-back, medication reconciliation completed before discharge, reassessment after bronchodilator treatment, appropriate escalation for worsening respiratory status, follow-up appointment completion, and patient understanding of warning signs. Balancing measures should track workload, alert burden, and unintended delay.

Numbers require context. A lower readmission rate may reflect better care, but it could also reflect barriers to returning. Patient-reported breathlessness, confidence, access to medicines, and experience of communication should accompany administrative outcomes. Improvement teams should review individual cases as well as aggregate data.

Conclusion

The six QSEN competencies provide a complete framework for nursing care. In COPD, patient-centered care defines goals and preferences; teamwork coordinates complex services; evidence-based practice guides interventions; quality improvement strengthens local reliability; safety prevents and responds to harm; and informatics makes information available for decisions. None of the competencies can substitute for the others. Excellent nursing care occurs when they are integrated at the bedside, across transitions, and in the design of the health system. (World Health Organization)

References

Quality and Safety Education for Nurses Institute. "QSEN Competencies."

<https://www.qsen.org/competencies>

Cronenwett, Linda, et al. "Quality and Safety Education for Nurses." *Nursing Outlook*, vol. 55, no. 3, 2007, pp. 122-131.

Global Initiative for Chronic Obstructive Lung Disease. *Global Strategy for the Diagnosis, Management, and Prevention of COPD*. 2026.

World Health Organization. "Chronic Obstructive Pulmonary Disease."