Safety and quality webquest essay

ASSIGN
BUSTER

“ Improve the safety of using medications” The rationale for this goal Is to positively Impact the safety of patients taking anticoagulant medications resulting In better outcomes. It Is also designed to help organizations reduce negative resident outcomes associated with medication discrepancies.

Goal 7: “ Reduce the risk of healthcare- associated infections” The rationale for this goal is to decrease the incidence of healthcare- associated infections by complying with the CDC or the WHO hand hygiene guidelines.

It is also designed to prevent central line- associated infections by implementing evidence- based practices. Goal 9: “ Reduce the risk of resident harm resulting in falls” The actionable for this goal is to reduce the risk of falls by evaluating the patients risk for falls and take action to reduce the risk of falling as well as the risk of injury, should a fall occur. The evaluation should include patients fall history, medications and alcohol consumption, gait and balance screening, assessment of walking aids, assessment of the environment, and assisted technologies and protective devices.

Goal 14: “ Prevent healthcare- associated pressure ulcers” (describes ulcers) The rationale for this goal is to utilize clinical practice guidelines to effectively identify tenants at risk and define early intervention for prevention of pressure ulcers. After viewing the videos write one paragraph (5 – 6 sentences) on each video on how this impacts health care involving both patients and healthcare professionals.

The partnership for patient’s initiative was designed to improve patient care and reduce the number of preventable Injuries occurring In hospitals.

This Initiative will Impact patients by improving the quality, safety, and cost of their healthcare. Healthcare professionals will have to work harder to Improve their skills and performance. They will be required to participate In Intensive training and educational programs.

Patients will be more closely monitored and their voices and pollens will be heard. This Annihilative will reduce hospital readmission, falls, pressure ulcers, Infections, etc.

The patient centered communication standards were released by the Joint commission and are designed to advance the Issues of effective communication. Cultural competence, and patient and family centered care. Health care professionals their communication practices. Upon admission, the nurse will be required to address patient communication needs.

These standards will impact patients by increasing their satisfaction with care. Patients will not be denied or ignored due to cultural, language, or sexual orientation differences.

What is the goal of the “ Speak Up” program? The goal of the speak up program is to urge patients to take an active role in preventing health care errors by becoming involved and informed participants on their health care team. What is the meaning of the mnemonic “ SPEAK UP”? Speak up if you have questions or concerns. If you still don’t understand, ask again.

It’s your body and you have a right to know. Pay attention to the care you get. Always make sure you’re getting the right treatments and medicines by the right health care professionals.

Don’t assume anything. Educate yourself about your illness. Learn about the medical tests you get, and your treatment plan.

Ask a trusted family member or friend to be your advocate (advisor or supporter). Know what medicines you take and why you take them. Medicine errors are the most common health care mistakes. Use a hospital, clinic, surgery center, or other type of health care organization that has been carefully checked out.

For example, The Joint Commission suits hospitals to see if they are meeting The Joint Commission’s quality standards.

Participate in all decisions about your treatment. You are the center of the health care team. There are currently how many “ Speak Up” Campaigns and videos? List them.

There are currently 21 speak up campaigns and ten videos. Campaigns: Help Prevent Errors in Your Care, Help Avoid Mistakes in Your Surgery, Information for Living Organ Donors, Five Things You Can Do to Prevent Infection, Help Avoid Mistakes With Your Medicines, What You Should Know About Research Studies, Planning Your Follow-up Care, Help Prevent Medical Test Mistakes, Know

Your Rights, Understanding Your Doctors and Other Caregivers, Prevent Errors in Your Child’s Care, Stay Well and Keep Others Well (a coloring book for children), Tips for Your Doctor’s Visit, Reduce Your Risk of Falling, Diabetes: Five Ways to be, Active in Your Care at the Hospital, Dialysis: Five Wars to be Active in Your Care at the Hospital, What You Need to Know

About Breastfeeding, What You Should Know about Stroke, What You Need to Know About Your Serious Illness and Palliative Care, What You Should Know About Adult Depression, What You Should Know About Memory

Problems and Dementia Videos: Prevent Errors in Your Care, Prevent the Spread of Infection, Take Medication Safely, At the Doctor's Office, Kid Power! , Reduce the Risk of Falling, Know Your Rights, Speak Up About Your Pain, Speak Up at Home, Ask Your Advocate to Speak Up Name the three (3) brochures that " Speak Up" has for Infant health care including: " Prevent errors in your child's care", " Stay well and keep others well (color book for children)", and " What you need to know about breastfeeding. " What do you think about the " Speak Up" programs?

How can this initiative improve patient outcomes? Provide rationale to support your answer). I think that the speak up programs are a great way to get patients to be involved in their personal health care. It encourages them to be educated about their illness and the care and treatment to follow. It explains to ask questions, not to be afraid, or to have someone advocate for you when they cannot advocate for themselves.

The speak up program can improve patient outcomes by giving them a better, safe experience and to help prevent health care errors.

Do you think that educated patients have better outcomes? Why (provide rationale)? Yes, I do believe that educated patients have better outcomes because having this knowledge of their disease and being active in their care and treatments can provide for a better quality of life for the patient. If a patient does their own research on their treatments and illness before a

doctor's appointment, they will be more prepared to ask appropriate question's that they might have. It can also minimize the need for additional medical services, preventing cost to them.

Also, when the patient has the knowledge of potential surgeries or testing that may be done, can reduce their fear and anxiety. Overall, patient education can result in satisfaction with the care they are receiving.

Are you surprised that hand hygiene is still a quality focus after all these years? No, I am not upraised that hand hygiene is still a quality of focus even after these years because infections are still being spread from patient to patient due to lack of compliance with hand hygiene.

Washing your hands is the single, most effective way to prevent infections and healthcare professionals along with family and friends of the patient still neglect to do so. So, why doesn't everyone wash? How do you ensure compliance? Hint: click on Read more about the Hand Hygiene Solutions). Causes of failure to clean hands may include ineffective placement of dispensers or sinks, ineffective or insufficient education, health care worker forget to their hands are full, or the perception that hand hygiene is not needed if wearing gloves.

There are many ways to ensure compliance with hand washing including making hand hygiene a priority performance expectation, and providing visible guidelines of proper hand washing throughout the facility and inside of restrooms.

Staff members could also remind other staff members to wash their hands. It is also important that we as nurses serve as a role model by practicing proper hand hygiene. All facilities should have accessible hand sanitized pumps and sinks throughout the facility as well as a counter or other type of surface that items can be placed on when hands are full.

Another important way to ensure compliance is to obtain compliance data and come up with a solution as to why hand hygiene is not being complied. Have you seen some form of “ Safe Hand-off occurring in your clinical area? Do you think this is an important initiative? Explain and give examples supporting your answer (this should e a two (2) paragraphs with 4-5 sentences or longer).

An example of a “ safe hand- off’ that I had witnessed occurred at the facility that I work for. The nursing manager was sending a patient from the intensive care unit to the rehab unit.

She had the patient’s family in which they discussed the reason for the transfer and the expected ongoing care and treatments to be provided. She also provided the receiving nurse with all appropriate documentation as well as precautions or concerns involving the patient. Both nurses followed- up with documentation of the transfer and all other expected responsibilities. I believe that the Hand- Off communications project is an important initiative because it promotes patient safety with successful transfers of patients along with patient and staff satisfaction.

It targets solutions for specific causes of hand- off communication failures. Examples of these solutions include teaching staff on what constitutes a

successful hand- off, making successful hand- offs an organization priority and performance expectation, the use of forms and tools such as checklists and SPAR tool, identification and communication of key information and critical elements of their patient from sender o receiver, sender provides details of patients history and status when speaking with receiver, and the receiver establishing an appropriate workplace to focus on the transferred patient.

Stop #3 Do these recommendations impact your future practice? If so, how? Yes, these recommendations impact my future practice because the use of licensed practical nurses are slowly declining and the demand for high level nurses are increasing. The pressure to continue education and get a higher degree is substantial. I plan on going back to school within the next few years to further my degree and in these commendations states that both state and private fenders should expand loans and grants which would help me achieve this goal. Stop Name the six steps to reduce harm and deaths.

The six steps to reduce harm and deaths include: 1) Prevent pressure ulcers by reliably using science- based guidelines for prevention of this serious and common complication. 2) Reduce MRS. infection through basic changes in infection control processes throughout the hospital 3) Prevent harm from high- alert medications starting with the focus on anticoagulants, sedatives, narcotics, and insulin.) Reduce surgical complications by reliably implementing the changes in care recommended by the surgical care improvement project (SKIP) 5) Deliver reliable, evidence- based care to congestive heart failure to reduce readmission.) Get Boards on Board by defining and spreading new and leveraged processes for hospitals Boards of

Directors, so that they can become far more effective in accelerating the improvement of care How many of them do you see implemented in your clinical site? Name those that are implemented and how they are being implemented. There are two out of the six steps to reduce harm and deaths that I eve seen implemented in my clinical sites.

The first step I have seen implemented most often is prevention of pressure ulcers using science- based guidelines.

They implement this step by performing weekly skin checks, keeping the patients skin clean and dry by frequently changing the patients both when incontinent and at regular intervals. Also applying moisture barriers during these changes. They also, reposition their patients every two hours to avoid pressure and formation of ulcers, in bed or in the wheelchair.

The second step that I have seen implemented at clinical is reducing MRS. infections. They implement this step by performing hand hygiene before and after contact with MRS. patients, or their immediate environment.

They have designated equipment for infected patients such as, stethoscopes, blood pressure cuffs, and thermometers. There are also contact precaution signs outside of infected patients rooms and appropriate personal protective equipment located in a cart outside of the patient’s room that is infected. Isolation of an infected patient was also implemented while at one of my clinical sites by transferring the infected patient to a private room. What changes can healthcare agencies and health care professionals make that will result in improvement in reducing MRS.

. (Your answer here should be a paragraph in length or more).

There are many changes that healthcare agencies and healthcare professionals can make that will result in improvement in reducing MRS..

These changes include improving hand hygiene. This can be done by installing hand sanitized dispensers throughout facilities, especially at the point of care. Gloves should also be available in patient's rooms, bathrooms, and throughout the facility. Clinical staff, including new ire's and trainees must demonstrate their knowledge and understanding of the key elements of hang hygiene as well as the appropriate technique when washing their hands.

The next changes are focused on decontamination of the environment and equipment, and improving active surveillance.

This can be done by educating staff on the importance of cleaning and the proper methods of cleaning. Complete a checklist for each cleaning to be done and document that all areas were cleaned including those that are " high touch". The checklist should include instructions such as, cleaning from areas furthest from the door to prevent recontamination. Verify compliance with cleaning and disinfecting techniques.

Other changes that can result in improvement in reducing MRS. include: provide appropriate notification to staff when an admission screening tests positive for MRS.

, so that precautions can be implemented immediately. Educate staff of the importance of infection control as well as the proper personal protective

equipment that should be worn. Educate staff on using the SABA tool which promotes appropriate communication. Staff should also communicate with each other every shift on the plan of care for the patient with MRS..

Stop #5 . What is a Sentinel Event?

Define root cause analysis as presented by The Joint Commission. A sentinel event is an unexpected occurrence or risk involving death or serious physical or psychological injury. Serious injuries specifically include a loss of limb or function. These events require immediate investigation and response. A root cause analysis is a developed action plan designed to implement improvements to reduce risk; implement the improvements; and monitor the effectiveness of those improvements.

2. There are several commonly identified root cause categories and subcategories

Blackman Story and provide the specific subcategory that is involved. Anesthesia Care- monitoring Assessment – Adequacy, timing, or scope of; patient observation; decisions Care Planning- Planning and/or collaboration Communication- Oral, written, electronic, among staff, with/among physicians, with patient or family Continuum of Care- Access to care Human Factors- Staffing levels, staffing skill mix, competency assessment, resident supervision Medication Use- Formula, ordering, patient monitoring Patient Rights- participation in care, pain management Rehabilitation- Rehabilitation care planning, patient monitoring .

Create a list of the characteristics Helen Haskell ascribes to a “ good” or professional nurse/physician. Knowledge of the side effects of medication Be task oriented Critical thinking skills Good communication skills Shows empathy Empowered as patient advocate Knowledge and courage 4. When Helen Haskell says “ patients need to be empowered and nurses need to embrace it”, how do you react to her suggestion?

I completely agree with this statement because your role as the nurse is to help your patients see the whole picture: to help them understand their diagnosis, treatment, risk factors, contributing actors, and what they need to do to help improve their outcomes.

It makes them self- reliant and independent, even if they need assistance to do it 5) Define professionalism and what it means to you. Professionalism is defined as the conduct, aims, or qualities that characterize or mark a profession or a professional person.

To me, professionalism means to set aside life outside of work and to adhere to the professional behavior when dealing with others. Being professional it important especially when working as a nurse. It is most appropriate for a nurse to speak in an appropriate manner when speaking to tenants as well as other nurses.

6) What factors in this hospital’s “ teamwork” culture might have contributed to the lack of response to Lexis’s parents concerns? Lack of communication between the nurses, Helen, and physicians is the main contributor.

Communication is the key element in teamwork culture and the nurses had failed to communicate with Helen by not listening to her concerns or calling the physician as she requested. A lack of respect towards Lewis and his family is also another contributing factor. 7. How might this story have changed if patients and families were considered part of the health care team? If patients and families were considered part of the health care team in this story, Lewis may have had a better outcome and a reduced chance of death.

It is important for patients and families to also help identify missed information that could have saved his life.

8. When Helen Haskell says she saw almost no evidence of teamwork, would you agree or not, and why? I do agree when Helen Haskell says she saw almost no evidence of teamwork because there was an extreme lack of communication between the nurses and physicians caring for Lewis. There were no proper assessments done or any immunization of signs that Lewis was declining. Teamwork in healthcare also includes the family members.

When Helen had requested certain changes in Lexis's treatments or when she had asked to speak to his doctor, no one worked together with her to make this happen. 9.

How does the culture in hospitals/health care agencies in which you've worked compare to the culture described in Helen Haskell story? In health care agencies that I have worked also had complications with teamwork culture. Communication was poor in the last facility that I had worked at and it was a common issue among the staff and patients. . What can health care

professionals do to create a hospital culture that supports effective teamwork and patient-centered care? Involve patients and families in the care process Provide patient education Collect feedback from patients and families Communicate information about the patient and their needs to other members of the healthcare team 11. Define professional accountability and what does it mean to you.

Professional accountability is defined as responsibility for the conduct of its members.

To me, professional accountability means to take responsibility to your own nursing actions and Judgment. 2. Helen Haskell describes nurses focused on task completion (including documentation of a plan of care) rather than on accurate assessment, application of knowledge, listening to patient and family, and action on the patient’s behalf.

How accurate is her depiction of nursing care you have observed? In instances where you have made similar observations, what contributes to this “ misplaced” work focus?

I believe that her depiction of nursing care is accurate. I have seen this happen in facilities that I have worked at. Nurses and other healthcare professionals tend to do their Job half fast. The reason for this includes the demand to get through all their documentation, having a great number of patients to care for, and the rush of finishing their shift on time. 13. What errors happened in Lexis’s story? The errors that occurred in Lexis’s story were the lack of communication.

There was no communication of concerns with the medication he was given.

Also, lack of critical thinking skills in an emergency situation was another main error. The nurses had assumed faulty equipment was the reason for his undetectable blood pressure rather than holding professional accountability for their lack of Judgment and knowledge of the potential adverse side effects. 14.

What is it about being a learner that can help prevent errors and adverse events? Being a leaner can help prevent errors and adverse events because continuing education ensures competency to practice safely.

It also improves your knowledge and skills needed for safe patient events for patients? Being a learner can also increase the risk of errors and adverse events because of your high demand to learn rather than actually caring for your patients 16. What policies or safeguards could help protect patients and families room a health care team’s inability to recognize a developing problem? Mandatory communication between all members and mandatory continuing education within the facility are ways to improve the healthcare team’s ability to recognize a developing problem. 7. Patients enter hospitals assuming that health professionals are watching for complications so that they can “ rescue” patients. What factors detract from our effectiveness in making that true – reliably true – for every patient? Factors that detract from our effectiveness in making this statement true include tenant alarms going off, new admissions, personal phone calls and working the floor understaffed.

18. Helen Haskell has stated elsewhere, “ We were in the only place in this country where Lexis’s father and I could not get help for our son… Hospital.

” In any other location, she could have called “ 911”. How do health professionals Justify this reality? What policies could eliminate the problem? Healthcare professionals could Justify this reality by having a communication board for the patients and families. Patients and families should have the knowledge of who to call to ask questions and authorities that are available to talk to. 19. What are your ideas about patient empowerment and nurse empowerment in terms of the overall safety of our health care systems?

When are the interests of patients and nurses in alignment? When are they not? Patients need to be aware of the medications they are taking and which nurse is caring for them each day.

They should also be provided with both written and verbal communication about their illness and what to expect for treatment. Nurses must know their policies and procedures. They must also build a rusting relationship with their patient by following through with requests by the patient and promises made to the patient.

The interests of patients and nurses are in alignment when it comes to care, following through with tests, having knowledge of medications.

20. What kind of courage do you think Helen Haskell believes we need to prevent Lexis’s story from happening again? I believe that Helen Haskell believes that we need the courage to stand up for our patients when policies go wrong and when there is a breakdown in communication. As a nurse we need to protect our patients and having courage is an important skill to have.