

# How can the five hro principles help health care organizations improve patient sa...

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BUSTER**

The paper "How Can the Five HRO Principles Help Health Care Organizations Improve Patient Safety?" is an exceptional example of an assignment on nursing.

Patient safety has been assessed by applying High-Reliability Organizing (HRO) principles. The HRO principles encompass: (1) operations sensitivity, (2) follow up of small failures, (3) reluctance to oversimplification, (4) deference to expertise and (5) resilience (Weick and Sutcliffe, 2001). HROs endeavor to avoid the occurrence of errors by insisting a strong and unwavering commitment to the concept and application of collective mindfulness (Spath, 2011). However, there are certain challenges for implementing the HROs. For example, Spath (2011) insists that most healthcare organizations lack the collective supportive safety culture along with process reliability. In other words, the healthcare environment and culture play a vital role in satisfying the objectives of healthcare organizations.

For overcoming these challenges, the healthcare organizations are required to understand the causes behind inadequate supportive safety culture and process reliability. Consequently, after knowing the causes or reasons, the healthcare organizations will be in a position to prescribe or determine solutions for the causes. At the same time, a reliability of healthcare process can be improved through providing quality healthcare services to patients. In this regard, sometimes, values, like patient's health, come first among all other options. For example, it is a standard practice that advance payment is made for receiving health care services from patients. In certain cases, after completing the full medical checkup, healthcare service charges can be

taken from patients. More clearly, developing a positive reputation in the community will be the most important step as it will, directly and indirectly, benefit the image of healthcare organizations.

Process measures and outcome measures work differently. In a particular healthcare setting, process measures are carried out to ascertain adherence to pre-determined guidelines whereas outcome measures are evaluated to assess health care quality and other desired and expected outcomes. For example, appropriate data sources for process measures include healthcare manuals, guidelines, medical journals, health care policies, and other directive issued by relevant health administration for particular diseases in a specific healthcare setting. On the other hand, the data source for outcome measures encompasses official record of mortality patients remains the most important source.

Examples of process measures encompass: Stroke and stroke rehabilitation: percentage of patients aged 18 years and older with the diagnosis of ischemic stroke or TIA who were prescribed ant platelet therapy at discharge was developed by the America Academy of Neurology; America College of Radiology; National Committee for Quality Assurance; Physician Consortium for Performance Improvement was published in 2010 September; Surgical care improvement project was carried out by the Centers for Medicare & Medicaid Services was published in 2013 January.

Outcome measures include: Perioperative protocol and its percentage in wound infections by wound classifications have been developed by Institute for Clinical Systems Improvement and was published in 2014 March, and Intra-procedure colonoscopy complication rate's percentage of patients who

developed one or more intra-procedure complications was developed by AAAHC Institute for Quality Improvement and was published in 2014 July.