

Evaluating how to ensure patient safety nursing essay



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PATIENT SAFETY

According to World Health Organisation (2010) Patient safety is the prevention and avoidance of adverse circumstances or injuries coming from health care process. Accidents, errors are common events that can occur in the clinical area. Safety arises from the interaction from different parts of the system: it does not live in a person, department or device. Patient safety is a branch of health care quality.

Patient safety could be defined as the prevention of errors and adverse effect associated with patients in health care. Health care has become more complex and more effective with greater use of medicines, treatment and more use of technologies; also, patient safety is the prevention of adverse effects to patients and prevention of errors associated with health care. In every care given there is a certain degree of unsafe practice, wrong procedure, side effects of drugs, hazards done by a faulty or substandard medical device used in the health system, human errors or system errors (latent) failures (World Health Organization, 2002).

Patient safety is a global issue whereby about 2.3% -16.6% adverse event rates have been documented from acute care hospitals. 1.4 million people worldwide have also been reported by the World Alliance for patient safety are suffering from acquired infections from hospitals and in the developed world 10% of patients admitted to modern medical hospitals acquire one or more infections.

In Africa and Asia pacific region, patient safety is a very big issue of concern.

In the developing countries the risk of health care associated infection is 2-
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20times higher than in developed countries, sometimes the percentage of health care acquired infection can exceed 25%. The countries rise of unsafe care is alarming (WHO, 2007, pp. 15).

Nursing literature and standards of professional conduct elevating patient safety and standard care all presuppose the importance of excellence in nursing practice. About what excellence is and how it may be operationalised as a moral essential in patient safety discourse is not well interpreted. It may not be possible to effect to any one specific definition of the idea what excellence in health and nursing care area is, but only to give examples of distinct excellences of professional practice and professional lives for example case of exceptional caring, exceeding honesty, outstanding understanding and skill, laudable wisdom, uncommon patience and eminent integrity.

RISK ASSESSMENT

It is the identification of attendant uncertainties in order to estimate the risk in an organization IPCS (2004). Risk assessment is the first constituent in risk analysis process which also includes management of risk and communication of risk. Risk assessment refers to techniques and methods that apply to the judgment of hazards. Risk assessment starts with problem formulation which includes four additional steps as elaborated below:

(1) Identification of hazards;

(2) Characterization of hazards;

(3) Assessment exposure;

(4) Characterization of risk (IPCS, 2004).

Identification of hazards entails recognizing the hazard and acting fast to prevent an incident from occurring. Characterization of hazards has to do with the drug, object or procedure that might cause the adverse effect. Assessment exposure involves how are patient expose to this hazards, how much danger is likely to occur, how long is the danger likely to occur, what measure of danger is appropriate for typifying health risk? Characterization of risk involves how does the assess exposure compare guidance value for the drug?

The nurses on duty in this case scenario did not act as harm absorbers by ensuring the safety of the young girl in the ward by combining expertise, experience and training which is required from experienced nurses. They needed mental alertness or foresight to identify on time that the patient tourniquet was not unfastened.

National Patient Safety Agency (2008) has developed a mental preparedness training program which aims at enabling nurses to increase knowledge of determinant that raises the chance of patient safety incidents, boost their confidence to keep patient safety incident from happening and understanding risk-prone situations better. Reason (2004) cultivated a method for analysing risks which was structured around the three-bucket model. According to the model, most patient safety incidents can be prevented if clinical staffs foresee error before any task, procedure or action is attempted. The assessment is divided into three parts, which are: the self-bucket, context-bucket and the task-bucket. Relating these three-bucket

prediction approaches to the case scenario examined in this essay is detailed below.

In the self-bucket, the registered nurse that collected the blood sample from the little girl had a low level of competence and experience because it is the duty of a medical laboratory scientist which she is not. She was not aware of the policies that governs the procedure and never took her time to cross-check what she was doing.

In the context-buck the registered nurse on duty lacked team support from her colleagues. The four registered nurses on duty would have shared the patients in the ward to themselves in a ratio of 10: 1 and the unfastened tourniquet would have been noticed by the staff nurse in charge of this young girl.

In the Task-bucket the registered nurse that collected the blood sample was unfamiliar with the task so did not remember to unfasten the tourniquet. She would have asked for a medical laboratory scientist who has more experience in this procedure and it would have help reduced the work load for this staff nurse because the ward was busy and full.

Reason (2004) noted that using foresight is a fundamental skill of an experienced registered nurse and for it to be more effective it must be practised. He goes on to say that healthcare professionals who needs to develop error wisdom, alertness and quick reactions needs to apply it, should use the simple three-bucket model of error which might help them the foresight factors that raises the chance of patient safety incidents. Training on risk assessment does not have to take place in classroom but can be <https://assignbuster.com/evaluating-how-to-ensure-patient-safety-nursing-essay/>

cultivated in forming part of clinical handovers, or of daily training programmes involving for example, manual handling and lifting which was not done by the nurses on duty in this scenario.

The training programme designed created to equip staff with prospective risk assessment abilities and a simple model needed for use in their everyday work. Its aim is to help nurses to do something to prevent incidents, improve nurses' knowledge of the factors that can be added to make patient safety incidents occur, educating nurses by encouraging them to share their experiences of patient safety incidents, improving their knowledge of risky situations.

The program also helps prepare staff nurses to undertake urgent risk assessments of risky situations by encouraging them to accept that errors can and will always occur and to be more alert of safety gaps where they work, know how to check situations before starting a task and so increases chances to minimise and avoid errors and to note and anticipate problems and to prepare in advance to deal with them. Ask for more qualified help when necessary and to know what stops them from asking for help.

THE SCENARIO

My patient case scenario happened in south-west Nigeria, West Africa where a student nurse did her clinical practice. An eight-year-old girl who was admitted for the treatment of malaria had her arm amputated before discharge from the hospital. This young girl as I will call her was admitted into a 40-bedded busy ward with just three trained registered nurses on duty on each shift. She came in with severe pyrexia which was later brought

down, but on the third day of her stay in the ward as a stable patient, the medical doctor on duty ordered for a malaria parasite blood investigation to see if there are more parasites before discharge.

Fortunately the hospital management board had enacted a law which governs the hospital and the laboratory in this hospital whereby blood samples are collected by the nurse on duty to the medical laboratory scientist because the hospital had only one medical laboratory scientist that runs the laboratory. The hospital management board tells the Federal Government that they have employed ten medical laboratory scientists (Ghost workers) but apparently employed just one.

On that faithful morning one of the registered nurses on duty collected this patient blood for investigations but forgot to unfasten the tied tourniquet from the patient's arm. The incident took place with the morning nurses on duty while handing over to the afternoon nurses the unfasten tourniquet was still on the patient arm so the tourniquet was there for two days without any of the nurses on duty noticing, the patient mum thought the on the girls arm was part of the treatment. 48 hours later a registered nurse on duty who went to give the patient bed bath saw it and by then blood supply to that arm has been cut off.

An incident report was filled and submitted to investigated the incidence but information collected could not be worked on appropriately because the structure of the management board is pathologic because they have this attitude already that they needed not to waste their time on patient safety issue (Parker, 2001)

SYSTEM FACTORS

Throughout management of care, registered nurses are used extensively. Most health management officers prefers using advanced practice nurses in their primary care duties in changing patients positions and in community settings. Another important role for the registered nurse is that of case management while on duty. As a case manager you will have to manage care for a patient during the whole of the health care system to minimize breakdowns, contain cost and improve the quality of life.

Nurses also help in a triage role, deciding the most suitable course of intervention and are often employed to render the most appropriate and cost-efficient care. This duty often involves moving a patient out of the hospital, a nursing home or with health service. The patients who are the consumers have different views towards managed care and their experiences. Some patients have good access, care givers they trust, various range of services and fair costs. Others have experienced access problem, refusal of treatment and limited coverage as seen in this case scenario. As patients become more informed, they began to fight for their rights to better health care services through legal system and reforms.

Reducing workforce as seen in this essay, without proper reconstruction simply leaves fewer people to realize already inefficient and ineffective work. Unluckily this short sighted approach is taken by various companies, both in and outside health sector. The outcome is poor morale, patient discontent, low-quality outcome and loss of able staff. Kuokkanen et al., (2003) in their studies noted that job satisfaction, empowerment and organizational obligations are closely linked.

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Health care workers today are facing a very different work environment. They mostly have seven to ten different jobs during a typical work career moderately than the three jobs or lesser held by former generation.

Keys to successful reconstruction of the health system include strong leadership, support from the leaders from the top (resources, cultural, financial and time) positive thinkers, steadfastness and our being able to answer these few questions:

- What is our mission?
- What standard do we want?
- How do we need to go about our work?
- What people do we want to work with?

The history, political and socioeconomic factors of a country determines the characteristics of the health system, for example the hospital where this incidence occurred , the organizational models are visionary and do not actually exist in a realistic pure state. Giving the Federal government a false figure of staff in each ward and having few staff is organisational failures that lead to the patient safety incidence. Due to the poor system normal daily nursing procedures were not carried out like taking of vital signs four hourly because if the normal routine procedure of taking vital signs was done the nurse that carried out the procedure would have seen the unfasten tourniquet that was tied on the little girls arm.

During handing and taking over of the morning nurses to the afternoon nurses, the blood specimen collection which was a latest development would have been reported to the head nurse on afternoon duty. The nurses on night duty also failed in their duties. If a proper night report was written and read out loudly by a night nurses in the presence of all the day duty nurses the next day the error would have still be noted.

Healthcare managers, strategy-makers and governors at the blunt-end-they decide on how care is delivered through strategies, financial control and directing the work of the healthcare professionals.

At the blunt-end, latent conditions occur. A working environment is made that increases the chances that there will be an active failure at the sharp end. There are a whole lot of latent failures-all with the possibility to cause an adverse event like what we have now in this patient case scenario. The healthcare system in this scenario is overloaded such as overbooking admissions into the ward with less staff. Normally there is a combination of many small factors, each appearing not to be important when viewed alone.

When latent failures occur in addition to only one active failure, such as forgetting to unfasten a used tourniquet by a registered nurse who is overtired because she has been working in an overcrowded and busy ward, the outcome is a recipe for an adverse event to occur.

HUMAN FACTORS

Human factor is the application of human knowledge, ability and limitations to the design of common systems of people, work tools and their

environment to guarantee their influence, safety and ease of use. The above <https://assignbuster.com/evaluating-how-to-ensure-patient-safety-nursing-essay/>

definition explains it further that the chores nurses perform, the equipment they are called to use, their work environment and the organizational procedures that moulds their activities may or may not be a good fit for their advantage and disadvantage. Poor outcome usually occurs when the sensory, behavioural and cognitive traits of providers are put together.

Most nursing work processes have evolved as a result of personal or practice first choice rather than through a systematic method of constructing a system that gives rise to small errors and greater effectiveness. Far too often, care givers and administrators have fallen into a current situation trap carrying out procedures simply because they always had been done that way. Experts in human factor on the other hand, look at human abilities and weakness in the construction of systems, stressing the importance of avoiding believe in memory, carefulness and follow up intentions-areas where human acts of avoiding confidence. Processes can be made easy and standardized, leading to less confusion, gains more effectiveness and fewer errors.

The area of human factors does not point solely on devices and technology. Human factor research came up during World War II as a result of showcasing equipment and controls that were not fitted to the visual and motor abilities of human users, decade after decade of human factors work has seen a broadening of the human accomplishment issues seen worthy of investigation. Lately a number of human factor experts with interest in improving health care standard and safety spoke addressing a more inclusive range of sociotechnical system factors, including only patient, care givers, the duty performed, and group work, but also work environments or <https://assignbuster.com/evaluating-how-to-ensure-patient-safety-nursing-essay/>

Microsystems. One of the lessons coming from a systems method is that meaningful improvements in safety and quality are likely to be reached by seeing to and correcting the mistakes among these organizational and management matters, and socioeconomic factors outside of the institution. Managing the systems confidence of care, as seen by confidence of care, is a big challenge faced by providers and their human factor partners.

Human factor relevant to this case scenario is that there was an inadequate flow of information from the nurses during their handing over process. The nurses on each shift did not have the information they needed to appropriately care for the young girl. The (Joint Commission) 2006 advices on the improvement of effective communication which is include a requirement for a standardized handing-off of communications. Other human factors that lead to the incident were fatigue, stress and interruptions.

Although the nurse that carried out the procedure was not a medical laboratory scientist but she should have explained the procedure to the young girl or get an interpreter to interpret the procedure to the patients mother because she does not understand English. This effective communication before the procedure would have helped in great deal in preventing this accident because the mother caring for her daughter would have noticed the tourniquet still fastened on her daughters arm after the procedure was an error and would have drawn the attention of the nurse or any other nurse to unfasten it.

CONCLUSION AND RECOMMENDATIONS FOR PRACTICE

Increasing the number of medical staffing in order to achieve compliance will help in minimizing patient safety incidence rather than lying. Although increasing the number of medical staff is not a criterion that error will be prevented completely in the practical world.

Setting up assessment team amongst the nurses who will be dedicatedly positioned to centralised areas in the ward to assess acutely ill patients and strict monitoring while still on admission.

No matter how bad the case in a hospital is, there must be a patient safety champion in each department or division which should be recommended or nominated by the staff in the hospital.

The hospital should use the information generated by its incident reporting system and organization-wide risk assessments to proactively improve patient care.