

The need for time and resources to support effective workflows in in healthcare s...

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According to Sotomayor's article, "Clinical nurse leaders; Fulfilling the promise of the role," (2017) nurses need to be at the forefront of workflow advancement. In his research, Sotomayor reported that nurses outnumber any other healthcare providers making them the "largest provider workforce in healthcare." He noted that publicly reported nurse-sensitive measures were a positive step towards improving quality. Sotomayor's research also reported fragmentations of care as a leading factor to 44,000-98,000 deaths per year from medical errors in the United States. He reported that his review of research over the past ten years only showed small improvements in error reporting and an increase in quality initiatives. He explained in his research that he supported the Institute of Medicine (IOM) 2010 report, nurses could improve the quality of care being delivered in the United States if they advance their education. Sotomayor's research supports the notion that nurses need to be at the forefront of designing health care systems and the way that nurses work.

Along with the research that supports the importance of nurses designing health care systems, research has also shown that nurses need to utilize systems thinking. Dolansky & Moore's article, "Quality and safety education for nurses (QSEN): The key is systems thinking," (2013) suggests that nurses utilize a skill called system thinking. According to Dolansky & Moore's research, systems thinking focuses on six competencies: patient-centered care, teamwork and collaboration, evidenced-based practice, quality improvement, and informatics. They explained that systems thinking requires all disciplines to collaborate, communicate, share and exchange information as a team to achieve the best outcomes for the organization.

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Dolanskey & Moore explained, systems thinking involves “ shared governance which engages people and increases quality and safety at the organizational level.” According to Anthony (2004), “ Shared governance is a model of nursing practice designed to integrate core values and beliefs that professional practice embraces, as a means of achieving quality care.”

Shared governance is characterized by autonomy, effective communication, interdisciplinary resource management and clear expectations. The characteristics of shared governance should be utilized across all healthcare disciplines interchangeably to improve the care delivery system. Dolanskey & Moore suggests using problem solving techniques like root cause analysis, flowcharts and diagrams to show how all healthcare disciplines are involved and must work together to improve safety and quality at the organizational level. Dolanskey & Moore’s research supports that systems thinking is essential to workflow process advancement.

Like Sotomayor and Dolansky & Moore previous research findings, Tetuan, Ohm, Kinzie, McMaster, Moffitt and Mosier’s article, “ Does systems thinking improve the perception of safety culture and patient safety?” (2017) research explained that nurses who commit medical errors are also victims because of poorly designed systems. Their research suggests that nurses are engaged in monitoring errors, assessing system failures and being aware of financial responsibilities and because of this, they understand how their actions or lack of actions impact the entire organization. Tetuan et al. research supports the three processes involved in mapping out workflows which include: a perceived process, reality process, and an ideal process.

Dolansky & Moore explained that systems thinking promotes engagement and communication across all disciplines which leads to each discipline realizing how important their roles are to the organization. This is important because no one discipline can improve the health care system alone. It must be a system-wide effort. Tetuan et al. expressed that medical errors can not be blamed on nurses without assessing the system for potential workflow failures. Stalter's article, "Using systems thinking to envision quality and safety in healthcare," (2018) reported that health care systems are not adequately utilizing systems thinking with quality and safety initiatives because the United States continues to report over 400, 000 deaths by medical error per year. Stalter suggests that we change the way that we are thinking about how to improve quality and safety. Evidently the way that we are thinking and acting now is not working because we still have a significant report of deaths by medical errors reported and not telling how many errors or deaths that aren't reported. Stalter suggests "total system transformation" which includes considering the way we think about how to improve safety and quality using systems thinking and having a way to measure and evaluate rather or not the process is effective. This affords the opportunity to address concerns and make changes to stay on track to improving care quality. The researchers work supports that systems thinking is important to improving processes and quality, however researchers differ in their beliefs of the extent to which systems thinking can resolve error issues related to workflow processes which would decrease or eliminate errors. The previous research supports the concept of nurses being at the forefront for designing, maintaining and tracking workflow processes. In

doing so, the nurses utilize system thinking and address the workflow process in its entirety.

Cain and Haque discuss another aspect of workflow advancement. In Cain and Haque's article, "Organizational workflow and its impact on work quality," the researchers explained why workflows are important to nurses. Cain and Haque explained that modern technologies and treatments in clinical areas, chronically ill patients with comorbidities, cost containment and multidisciplinary teams caring for patients with new role definitions lead to confusion about who can and will perform certain tasks. They also suggest identifying nurses with the ability to handle pressure when delivering safe and efficient care. The researchers also suggest implementing a reimbursement arena based on patient-centered care. Through suggesting that updated workflows will greatly improve the nursing profession, Cain and Haque explain why workflows are important to nurses.

While Cain and Haque's research explained how workflows are important to nurses, McGonigle and Mastrian aim to assess the issues that arise within workflows. McGonigle & Mastrian's article, "Nursing informatics and the foundation of knowledge," (2015) defines workflow analysis as an observation and documentation of workflow to better understand what is happening in the current environment and how it can be improved. The researchers conducted a strategic analysis when diagnosing the issues in medical care workflows. According to McGonigle and Mastrian, a strategic analysis looks at how work is done by users to facilitate the design of appropriate human-computer dialogues. By conducting a strategic analysis

on medical workflows, McGonigle and Mastrian found that technological implementations that fail to address workflow not only potentially lead to issues with patient safety and quality of care, but also may have a negative fiscal impact on the organization. When technology doesn't support the goals of the care team, it often causes workaround workflows.

Another issue that arises with workflows are workarounds. Workarounds occur when nurses develop processes to complete a task that differ from the established protocol. Exacerbation of problems due to duplicated or outdated workflow systems lead to workarounds. Debono et al.'s article, " Nurses; workarounds in acute healthcare settings: a scoping review," (2013) explained that nurses don't intentionally develop workarounds. Through their research, Debono et al. discovered that nurses often choose to use workarounds instead of following established protocol when presented with a system of expectations that aren't conducive to functioning. The researchers found that nurses consider their experience, skills, and knowledge substantial when developing workarounds. The issue of nurses following their own workarounds instead of following protocol is a prominent safety issue in the medical field today. To help solve this issue, the reason nurses feel compelled to develop workarounds must be developed. Because of their research, Debono et al. explained that poor leadership, lack of involvement with nurses in decision making and lack of opportunities for professional development in nursing are the issues that lead to nurses developing workarounds. Leaders should consider nurses loyalties, expectations and end goals within the organization. It's important to know not assume what nurses

feel like they will gain or lose when caring for patients. To improve workflows, the issue of workarounds must be addressed and to resolve the issue of workarounds, we must first address the underlying factors that compel a nurse to steer away from protocol. Workarounds, while a substantial contributor to workflow failures, are not the only issue with medical workflows. Nurses are often blamed for negative patient outcomes, Henneman suggests that the system itself may also contribute to failure. In Henneman's article, "Recognizing the ordinary as extraordinary: Insight into the "way we work" to improve patient safety outcomes," (2017) Henneman suggests that organizations need to "assess their workflow systems for system and human factors that influence patient's outcomes." While Henneman does not completely discount the possibility of nursing errors, he does emphasize the importance of nurses preventing patient harm. Henneman explains that the Nursing Intervention Classification System is one tool utilized to prevent or decrease the likelihood of harm to patients. The Nursing Intervention Classification System includes standardized language and interventions for nursing care activities. Despite the system being standardized it is inadequate in measuring things like staff workload because it lacks considering time and resources needed to carry out each nursing intervention listed. Leaders are cautioned to consider time and resources available when making evidenced-based staffing decisions. Henneman's research supports Debono et al.'s claim that the underlying issues leading to workflow discrepancies should be addressed first when developing a solution to workflow failures.

While Debono et al. and Henneman discuss the need for solutions to workflow failures, Foster provides a possible resolution. In Foster's article, "Changing lives-it starts with a plan" (2017), Foster suggests utilizing sustainability and transformation plans (STP's) based on place-based care to solve workflow issues. To better workflow protocol, Foster recommends that organizations base their protocols from their local population's needs. He also suggests that organizations clearly communicate with their business affiliates, identify the workforce needed, assess and reassess their service lines and plan to provide the best care. While Foster provides prospective solutions, his solutions do not address the entire scope of issues that lead to workflow error.