Human resources for patient care

ASSIGN BUSTER

4. 2 Capstone – Information and Literature Review

CASE SOLUTION

Information and Literature Review

Through an extensive study of the patient harm categories, human resource management, and payor mix at Union Health Systems, Inc., the research and analysis have identified the top elements of patient harm, discusses the human resource management function, and discusses some of the financial aspects of patient harm.

“ Healthcare is striving to become an industry of high-reliability organizations, and part of being a high-reliability industry means staying vigilant and identifying problems proactively” (ECRI Institute, 2018, p. 1). Providing exceptional patient care that is safe and compassionate is an invaluable resource in the healthcare industry. Union Health Systems strives to be the first choice hospital in the Wabash Valley. To accomplish this goal, they must provide brand value. “ So it comes down to scarcity, one product or service having qualities you won’t find everywhere or ideally, anywhere” (Olenski, 2015, para. 19).

UHS employees working in the clinical areas of the hospital are tasked with the great responsibility of overseeing the health and care of their patients. . “ Healthcare organizations must provide a safe environment for patients to receive care, and therefore a commitment to implement evidence-based HAI prevention strategies” (S. Johnson, 2018, p. 130).

Utilizing a sophisticated reporting system allows UHS to monitor safety events which includes “ near miss” reporting. These types of incidents do not cause harm but provide the organization with insight into processes or situations that could result in preventable harm. “ Near miss events are less likely to provoke guilt or other psychological barriers to reporting” (Harth, 2007, p. 101). Reporting preventable adverse events (PAEs) occurring within the hospital will provide the foundation for adjusting patient care while failing to report PAEs will undermine the hospitals’ credibility (DeWitte, 2016)

When patients seek medical care, the expectation is they will receive quality care in both areas of physical and emotional treatment. Deviations in quality of care may affect a patient’s quality of life, and more than likely will increase the time spent in the hospital to recover. “ Determining deviation is at the core of the classification system. It is the critical link to determining whether harm is preventable” (Hoppes & Mitchell, 2014, p. 15). The more time a patient spends in the hospital, the greater their risk of experiencing a serious safety event. When preventable harm occurs, not only is the patient impacted, but their family, friends, colleagues, and acquaintances are affected as well. In this day of viral postings, videos, and stories, the range of people made aware of the harm is multiplied exponentially.

Promoting a Culture of Safety and Quality Care

Leadership and Ethical Decision Making

Reducing the number of hospital-acquired injuries requires changes to occur at both the organizational and individual level. The foundation of an organizational culture centered around patient safety and quality care must

start at the top and trickle down. Change is one of the most difficult and unsuccessful initiatives to manage. Change brings a lack of understanding and commitment, fear, and uncertainty, and requires a workforce that is committed. Black (2014) discusses three elements of change See, Move, and Finish that are essential in leading change initiatives. The organization has realized the need for change, must move to ensure the employees have the resources needed to feel confident during the change and finish strong by implementing or changing the reward system. Diversity in the workforce calls for diversity in the mix of rewards and incentives to successfully recruit and retain employees who will be successful at implementing change. " The overall ideal total reward mix includes financial and non-financial rewards when offered to employees in a manner that is reliable with preferences to gender, race, and age cohorts" (Pregnolato, Bussin, & Schlechter, 2017, p. 9). Capturing and communicating results is valuable as it shows employees their hard work is having a positive impact on the organization.

Patient safety has come under increased scrutiny in recent years, and reimbursement adjustments are being made based on the value of care and patient satisfaction scores. These changes lead to increased pressures to make decisions that are more cost-efficient, which may not be in the best option for the patient. " The tension between financial incentives and patient choice also straddles the topic of patient outcomes and the financial bottom line" (Westling, Walsh, & Nelson, 2017, p. 6). It is imperative to the success of the organization to have the right leaders in place. " Improving patient safety and creating a culture of safety may depend, to a great extent, on leadership and communication in healthcare organizations" (Auer,

Schwendimann, Koch, De Geest, & Ausserhofer, 2014, pp. 23–24). Leaders within the organization are accountable for the ethical decisions made at the patient care level, at the system level, and the community level. Key markers of highly ethical organizations consist of humility, zero-tolerance, justice, integrity, trust, and social responsibility (C. Johnson, 2015). UHS has implemented system-wide ethical policies and procedures which creates a working environment where ethics are at the forefront of decision-making processes. Developing and implementing a proactive ethical framework for making decisions has many benefits including developing a familiar approach that can be applied in everyday work, focuses on the root causes of ethical conflicts, normalizes ethical considerations, and provides usefulness as an evaluation tool (Pavlish, Brown-Saltzman, & Fine, 2013).

Communication

Union Health Systems spans over multiple locations and has several layers of management. The Leadership Team is comprised of Administrative Officers, Directors, Managers, and Supervisors. Leaders at the manager and supervisor level are responsible for leading and engaging employees. Communication through several layers may lead to miscommunication or lack of communication. “ Filtering poses serious problems in organizations. As messages are communicated downward through many organizational levels, much information is lost“ (Bateman, Snell, & Konopaske, 2017, p. 485). Leadership meetings are held regularly throughout the year. However, employees at the staff level are rarely informed of the outcomes of these meetings. Lack of communication may result in a workforce that lacks trust,

is disengaged, unsure of the organization’s mission, or lacks job security which leads to low morale.

Communication at the patient level is also important. Complete transparency and communication when discussing adverse events with patients who are harmed does not necessarily lead to increased lawsuits. According to research by Stanford Medicine, “ Our findings suggest that communication-and-resolution programs will not lead to higher liability costs when hospitals adhere to their commitment to offer compensation proactively” (Duff-Brown, 2017, para. 9). One crucial form of communication when working in the health care industry is nonverbal. For example, learning to project caring and sympathy through facial expressions may help soothe emotional pain of patients and their loved ones who are harmed. People can usually read someone else’s feeling from facial expressions (O’Rourke, 2013).

Human Resource Management

“ Out of all the resources available, human resource is the most crucial to enable an organization to compete and excel in the current competitive marketplace” (Jha & Kumar, 2016, p. 21). When considering a serious safety event (SSE), the event must be classified as preventable. “ The American Society for Healthcare Risk Management (ASHRM) defines a Serious Safety Event (SSE) as a deviation from generally accepted practice or process that reaches the patient and causes severe harm or death” (Hoppes, Mitchell, Venditti, & Bunting, 2012). Reducing the number of preventable SSEs can only be attained through continued improvements within the organization

which includes allocating resources to invest in the workforce and maintaining a culture where employees feel valued. . “ Satisfied followers are more likely to remain with the company and engage in activities that help others at work” (Hughes, Ginnett, & Curphy, 2015, p. 332). A workforce that is fully engaged will result in a more efficient and productive and will work harder to achieve the organizational goals. “ Various studies show that engagement enhances not only the non-financial performance but also the financial performance” (Jha & Kumar, 2016, p. 21). Reducing patient harm counts must be a collaborative effort across all departments in the organization. “ Well-functioning team processes shape positive employee attitudes by allowing employees to coordinate each other’s work, jointly decide on how work objectives are to be attained, support one another, and achieve higher levels of performance” (Ogbonnaya, Tillman, & Gonzalez, 2018, p. 476). Developing cross-functional teams will bring an outside perspective and insight to various areas within the hospital. Exploring training in the area of Multi-team systems (MTS) needs to be distinct from traditional teamwork training and could provide novel performance measurement systems (Buljac-Samardzic, Dekker-van Doorn, & Maynard, 2018).

Financial Impact

Changes in medical reimbursements and technology are changing the landscape of care. Costs are on the rise while reimbursements are based on patient satisfaction scores, length of stay, and readmissions. Healthcare organizations may be forced to compromise patient safety for reduced costs and limited investments. Financial managers must evaluate proposed

investments and determine whether value would be added (Ross, Westerfield, & Jordan, 2013). Substantial costs incurred by the hospital related to serious safety events include litigation, reduction or elimination of reimbursments for services rendered, and workman's compensation costs. Patient satisfaction scores are directly related to Medicare and Medicaid reimbursements. The Centers for Medicare & Medicaid Services (CMS) use a value-based system which incorporates patient satisfaction scores into its' inpatient prospective payment system (HCPRO Staff, 2016). One of the top categories of patient harm at Union Health Systems is employee injuries. Many healthcare employers focus on the cost of employee injuries as the catalyst for implementing a safe patient handling and moving program (Nelson, 2015, p. 10).

References

- Auer, C., Schwendimann, R., Koch, R., De Geest, S., & Ausserhofer, D. (2014). How hospital leaders contribute to patient safety through the development of trust. Journal of Nursing Administration, 44(1), 23–29. http://dx. doi. org/10. 1097/NNA. 0000000000000017
- Bateman, T., Snell, S., & Konopaske, R. (2017). Management: Leading & leading & collaborating in a competitive world (12th ed.). New York, NY: McGraw-Hill Education.
- Black, J. S. (2014). It starts with one (3rd ed.). Upper Saddle River, NJ: Pearson Education, Inc.
- Buljac-Samardzic, M., Dekker-van Doorn, C., & Maynard, T. (2018). Teamwork and teamwork training in health care: An integration and a

path forward. Group & Organization Management, 43(3), 351–356. http://dx. doi. org/10. 1177/1059601118774669

- DeWitte, D. (2016, February 22). ‘ Hospital harm’ costs Iowans billions. Corridor Business Journal. Retrieved from http://web. b. ebscohost. com/ehost/detail/detail? vid= 1&sid= 8d32f459-8150-432b-853f-26c036b78332%40sessionmgr104&bdata= JnNpdGU9ZWhvc3QtbGl2ZQ%3d%3d#AN= 113196880&db= bwh
- Duff-Brown, B. (2017). In patient injury cases, revealing facts, offering apology does not lead to increase in lawsuits. Retrieved from https://med. stanford. edu/news/all-news/2017/10/in-patient-injury-cases-offering-apology-does-not-lead-to-lawsuit-increase. html
- ECRI Institute. (2018). Top 10 patient safety concerns for healthcare organizations 2018. Retrieved from https://www. ecri. org/EmailResources/PSRQ/Top10/2018_PSTop10_ExecutiveBrief. pdf
- Harth, I. (2007). Critical incident reporting: Learning from errors to improve patient safety. CONNECT: The World of Critical Care Nursing, 5(4), 101–103. Retrieved from http://web. b. ebscohost. com/ehost/detail/detail? vid= 12&sid= bc54e93c-b7f7-4659-83a9-90f61585fa96%40pdc-v-sessmgr05&bdata= JnNpdGU9ZWhvc3QtbGl2ZQ%3d%3d#AN= 106196602&db= ccm
- HCPRO Staff. (2016). Improve patient satisfaction scores, boost Medicare reimbursement. Retrieved from https://www. healthleadersmedia. com/strategy/improve-patient-satisfaction-scores-boost-medicare-reimbursement
- Hoppes, M., & Mitchell, J. (2014). Serious safety events: A focus on harm classification: Deviation in care as link getting to zero white

paper series — Edition no. 2 [White paper]. Retrieved from American Society For Healthcare Risk Management website: http://www. ashrm. org/pubs/files/white_papers/SSE-2_getting_to_zero-9-30-14. pdf

- Hoppes, M., Mitchell, J. L., Venditti, E. G., & Bunting, R. F., Jr. (2012). Serious safety events: Getting to zero. Retrieved from http://www. ashrm. org/pdfs/ASHRM-Whitepaper-Getting-to-Zero-Vol-1. pdf
- Hughes, R. L., Ginnett, R. C., & Curphy, C. J. (2015). Leadership: Enhancing the lessons of experience (8th ed.). New York, NY: McGraw-Hill Education.
- Jha, B., & Kumar, A. (2016). Employee engagement: A strategic tool to enhance performance. Journal for Contemporary Research in Management, 3(2), 21–29. Retrieved from http://web. a. ebscohost. com/ehost/detail/detail? vid= 2&sid= 824f4459-9246-4cd9-9d2a-eef105880ecc%40sdc-v-sessmgr05&bdata= JnNpdGU9ZWhvc3QtbGl2ZQ%3d%3d#db= bth&AN= 117637764
- Johnson, C. (2015). Meeting ethical challenges of leadership: Casting light or shadow (Fifth ed.). Thousand Oaks, CA: Sage Publications, Inc.
- Johnson, S. (2018). A case study of organizational risk on hospital-acquired infections. Nursing Economic$, 36(3), 128–135. Retrieved from http://web. a. ebscohost. com/ehost/detail/detail? vid= 9&sid= fe5313fc-91c7-49c4-9ddf-ce3a50959d57%40sdc-v-sessmgr02&bdata= JnNpdGU9ZWhvc3QtbGl2ZQ%3d%3d#db= ccm&AN= 130397389
- Nelson, K. (2015). Safe patient handling and health care reform: An opportunity to link patient and worker safety. American Journal of Safe Patient Handling & Movement, 5(1), 9–12. Retrieved from http://web. b. ebscohost. com/ehost/detail/detail? vid= 11&sid= c44fd423-fd9c-4a4f-

9133-4917084222e5%40sessionmgr101&bdata= JnNpdGU9ZWhvc3QtbGl2ZQ%3d%3d#db= ccm&AN= 103778727

- Ogbonnaya, C., Tillman, J. C., & Gonzalez, K. (2018). Perceived organizational support in health care: The importance of teamwork and training for employee well-being and patient satisfaction. Group & Organization Management, 43(3), 475–503. http://dx. doi. org/10. 1177/10596011187672
- Olenski, S. (2015). Brand value: What it means (finally) and how to control it. Retrieved from https://www. forbes. com/sites/steveolenski/2015/09/15/brand-value-what-it-means-finally-and-how-to-control-it/#6b6e047013b2
- O’Rourke, J. (2013). Management communication: a case-analysis approach (5th ed.). Upper Saddle River, NJ: Pearson Education, Inc.
- Pavlish, C., Brown-Saltzman, K., & Fine, A. (2013). Making the call: A proactive ethics framework. Healthcare Ethics Committee Forum: An Interprofessional Journal on Healthcare Institutions’ Ethical and Legal Issues, 25(3), 269–283. Retrieved from http://web. b. ebscohost. com/ehost/detail/detail? vid= 1&sid= 3e6b08f9-a5c6-4e6f-b533-8b4021f301d9%40pdc-v-sessmgr02&bdata= JnNpdGU9ZWhvc3QtbGl2ZQ%3d%3d#AN= PHL2213270&db= phl
- Pregnolato, M., Bussin, M. H. R., & Schlechter, A. (2017). Total rewards that retain: A study of demographic preferences. South African Journal of Human Resource Management, 15(1), 1–10. http://dx. doi. org/10. 4102/sajhrm. v15. 804
- Ross, S., Westerfield, R., & Jordan, B. (2013). Fundamentals of corporate finance (11th ed.). New York, NY: McGraw-Hill Education.

- Westling, C. R., Walsh, T., & Nelson, W. A. (2017). Perceived ethics dilemmas among pioneer accountable care organizations. Journal of Healthcare Management; Chicago, 62(1), 18–27. http://dx. doi. org/10. 1097/00115514-201701000-00005