Collaborate on Quality: Issue Analysis & Leadership Action Plan

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Maintaining a safe environment is of utmost importance in healthcare to ensure patient safety and prevent medical errors. According to Makary & Daniel (2016), medical errors encompass unintended acts or deviations from the care process that may or may not harm the patient. As healthcare technology advances, it is crucial for healthcare workers to take necessary measures to prevent such errors. At Vila Health Independence Medical Center, three medical errors occurred, highlighting the need for intervention and prevention. The incident on the pediatric unit on the eighth floor involved two patients with similar names and birthdates, B. Moore and B.R. Moore. This similarity in patient information contributed to the confusion and lack of attention, ultimately resulting in a medication error. The unit's shortage of staff and heavy workload further hindered their ability to properly differentiate between patients. Fortunately, the error was identified early, preventing any harm to the child, but it serves as a critical reminder of the potential consequences that could have arisen.

Additionally, the incident revealed a breach of confidentiality when two employees discussed the medication error at the front desk, where unauthorized individuals could overhear the conversation. This breach not only compromised patient privacy but also added unnecessary stress and concern for the involved parties, including one of the patient's mother. The goal of analyzing these errors is to identify the root causes and develop strategies to prevent similar errors in the future. One focus will be on addressing the causes of medication errors, including implementing protocols for proper patient identification before administering medications. This can involve the use of patient identifiers such as full name, date of birth, and photo identification, as well as utilizing barcode scanning technology for medication verification. Additionally, promoting effective communication techniques among healthcare staff will be essential to prevent breaches of patient privacy and maintain confidentiality. This can involve education and

training on the appropriate use of private spaces for discussions and reinforcing the importance of respecting patient privacy. By addressing these key elements, such as medication safety, patient identification, and communication, we can enhance patient safety and reduce the likelihood of similar errors occurring in the future. It is crucial to learn from these incidents, implement preventive measures, and foster a culture of patient safety and open communication within the healthcare organization.

Culture

The cultivation of a safety culture is a crucial objective for healthcare organizations, as it has a direct impact on patient outcomes and the overall quality of treatment provided. In terms of patient safety, communication, and privacy, the existing organizational culture involving medical errors appears to be deficient. Leadership commitment and accountability are crucial, with leaders setting clear expectations, providing resources, and promoting a blame-free learning and improvement environment (Marx, 2019). Open communication and collaboration should be encouraged to enable for incident reporting, information sharing, and inter-disciplinary cooperation. According to Marx (2019), staff members should be provided with education and training programs that emphasize patient safety, quality enhancement, and effective communication techniques. By implementing these strategies, the organization can establish a culture in which patient safety is prioritized, communication is open and effective, and continuous learning and improvement are embraced. Ultimately, this will result in enhanced patient outcomes and a secure healthcare environment.

IHI Triple Aim

The IHI Triple Aim is a framework created by the Institute for Healthcare Improvement (IHI) to improve the efficacy of the health care system. It consists of three interconnected goals: enhancing the patient experience of care, enhancing population health, and decreasing the per capita cost of health care. The IHI Triple Aim is applicable to the specific incident involving medical errors and violations of confidentiality (Kokko, 2019). The incident demonstrates the need for improved patient safety measures, effective communication, and privacy protections. By addressing these issues, the organization can strive to provide patients and their families with a safer and more satisfying experience.Several elements can be incorporated into a strategy for organizational development based on the IHI Triple Aim. Improving patient safety practices by instituting evidence-based protocols, conducting regular safety assessments, and promoting a safety culture would be consistent with the objective of enhancing the patient experience of care. This would aid in the prevention of medical errors and increase patient confidence and trust in the organization (Kokko, 2019). Second, addressing population health may involve implementing strategies to identify and resolve underlying systemic issues, such as staff shortages and overwork that contribute to medical errors. By prioritizing adequate personnel levels and burden management, the organization can improve patient outcomes and the overall health of the population (Kokko, 2019).Thirdly, the per capita cost of health care can be reduced by implementing efficient processes and systems that minimize waste, eradicate superfluous procedures, and maximize resource allocation. This can be accomplished by effectively utilizing technology, streamlining workflows, and instituting evidence-based practices that increase efficiency and decrease costs. By incorporating these elements of the IHI Triple Aim into the organizational transformation strategy, the organization will be able to optimize the performance of the health care system. This will result in enhanced

patient experiences, improved population health outcomes, and more sustainable resource utilization.

Leadership & Collaboration Strategies

Important departments must be directly involved in the corrective action process in order to establish a safety and quality culture. The Nursing Department should be directly involved in addressing medical errors and fostering confidentiality. Nurses are at the vanguard of patient care and play a crucial role in the administration of medications and patient safety. Their contribution and collaboration are essential for identifying fundamental causes, devising and implementing effective interventions, and assuring the observance of safe practices. Engaging the nursing department will not only cultivate a sense of ownership and accountability for patient safety and quality within the organization (Stemn et al., 2019), but it will also provide valuable insights and expertise.

Health Information Management (HIM) Department should also be involved. (Di Simone et al., 2020) HIM professionals are responsible for administering and protecting patient health information, including assuring confidentiality and compliance with privacy regulations. In order to address the breach of patient confidentiality that occurred during the incident, their knowledge of information privacy and security is essential. Involving the HIM Department will aid in the identification of information management process deficiencies, the development of pertinent policies and procedures, and the implementation of privacy safeguards. In addition to involving key departments, it is essential to involve specific leaders within the organization who can contribute to addressing the issue and promoting a safety and quality culture (Han et al., 2020). The Chief Nursing Officer (CNO) should play a pivotal role in directing the nursing department's

participation in patient safety and quality improvement initiatives. The CNO can provide the necessary direction, support, and resources for the effective implementation of corrective actions.

The Chief Medical Officer (CMO) is an additional important leader who should be involved. The CMO can unite the medical staff, align their efforts with patient safety and quality enhancement objectives, and advocate for evidence-based practices. Their participation is essential in instituting modifications to medication administration protocols, clinical decision-making, and interprofessional collaboration (Han et al., 2020). To enlist the assistance of these leaders and promote a safety and quality culture, best practices such as explicit communication, education and training, regular reporting and monitoring, and accountability measures should be implemented. Engaging leaders through regular meetings, providing data-driven insights on the impact of the incident, and providing opportunities for collaborative problem-solving can cultivate a shared understanding of the issues and a commitment to their resolution. Establishing performance metrics and mechanisms for feedback and recognition can further reinforce the significance of patient safety and quality as top organizational priorities, according to Han et al. (2020).

Leadership Action Plan

To establish a safety and quality culture and address the incident, a leadership action plan based on empirical evidence can be proposed. First, it has been demonstrated that transformational leadership positively affects patient safety and quality outcomes. This approach to leadership inspires and motivates employees by establishing a clear vision, nurturing collaboration, and promoting innovation. (Lappalainen et al., 2019) Leaders can engage in active communication, provide support and resources, and enable staff participation in decision-making

processes. Leaders can establish a culture of continuous improvement and accountability by implementing transformational leadership.

Second, effective communication is essential for promoting a culture of safety and quality. According to Lappalainen et al. (2019), executives should ensure that there are open communication channels throughout the organization so that employees can report incidents, communicate concerns, and provide feedback. Implementing routine huddles, meetings, and briefings can improve communication and foster a culture of openness. In addition, executives should promote active listening and foster an environment where employees feel secure discussing safety concerns.

Thirdly, it is essential to promote a culture of learning and continuous improvement. Leaders should support and encourage staff members' ongoing education and professional development. This may involve training on patient safety protocols, evidence-based practices, and error-prevention strategies. Leaders should also facilitate regular audits, performance evaluations, and quality improvement initiatives in order to identify areas for improvement and implement best practices supported by evidence (Han et al., 2020). By cultivating a culture of learning and continuous improvement, executives can improve the organization's capacity to effectively respond to incidents and mitigate risks. Establishing a safety and quality culture requires leadership strategies supported by evidence. Transformational leadership, effective communication, and a culture of learning and continuous improvement are three essential strategies that can aid in resolving the incident and addressing the organizational issue. By implementing these strategies, leaders can establish a culture that places a premium on patient safety, quality care, and continuous improvement.

Opportunities to Enlist Governing Board

The governing council of the organization plays a crucial role in supervising the organization's quality and safety initiatives. They are responsible for setting the organization's strategic direction, establishing policies, and providing oversight to ensure the delivery of safe and high-quality care. Their participation is crucial to nurturing a fair and just culture. To enlist the governing board's assistance in the improvement initiative, it is essential to maintain regular communication with them and provide them with pertinent information (Di Simone et al., 2020). Include quality and safety updates in board meetings, present data on key performance indicators, and share reports on incident investigations and improvement initiatives. By providing them with exhaustive information, the board of directors can gain a deeper comprehension of the organization's safety and quality landscape and actively participate in decision-making processes (Zhou et al., 2018).

In addition, it is essential to emphasize the influence of a fair and just culture on patient outcomes, employee engagement, and organizational reputation. Sharing research and case studies that demonstrate the benefits of a fair and just culture can increase the board's understanding and support for the improvement initiative. In addition, emphasizing the board's role as advocates for patient safety and quality care can encourage their participation and dedication. It would be beneficial to provide the governance council with updates on the organization's current safety and quality performance, including any trends or development opportunities. Sharing benchmarking data that compares an organization's performance to industry standards can also aid in gaining a broader perspective and identifying problem areas. According to Lee et al. (2019), providing information on best practices, regulatory requirements, and emerging trends in quality and safety can assist the board in remaining informed and guiding

their decision-making. By actively involving the board in the development initiative and providing them with comprehensive data, the board can play a crucial role in promoting safety and quality improvements across the entire organization.

Conclusion

Everyone's primary responsibility in a hospital setting is to assure the safety of patients and personnel. Although it is impossible to guarantee that medical errors will never occur, precautions are taken to avoid unanticipated complications. Despite greatest efforts, medical errors were discovered at Vila Health; thus, medical error. If not discovered in time, these errors had the potential to cause severe injury to the patients involved. Adopting the Triple Aim strategy can be advantageous for enhancing the health system's effectiveness. This strategy focuses on augmenting patient care, boosting population health, and decreasing costs. By addressing the fundamental causes of medical errors and fostering a fair and just culture, the organization can encourage interdepartmental coordination and collaboration. This establishes a culture in which healthcare workers feel comfortable disclosing errors and receiving positive reinforcement from management. In a just society, it is essential to regard human error, irresponsibility, and recklessness differently, allowing for appropriate accountability and learning opportunities. Through coordinated efforts, a culture of openness, and collaboration, the organization can aspire for continuous improvement and provide patients with safer, higher-quality care.

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