Syllabus

Course Overview

This course focuses on safety, quality improvement, and risk management in health care. You will apply various models to address the safety and quality of patient care and outcomes, decrease the risk of litigation, and effect positive change. This course will reinforce the importance of culture and organizational leadership in driving safety and continuous quality improvements efforts throughout health care organizations. Throughout the course, you will also focus on key skills related to preparing a quality dashboard, using such common quality improvement tools as statistical analysis, plan-do-study-act (PDSA), Six Sigma, and rapid-cycle improvement.

Course Competencies **(Read Only)**

To successfully complete this course, you will be expected to:

1. Analyze the quality and performance improvement activities within the health care organization.
2. Explain the risk management function in the health care organization.
3. Analyze the importance of patient safety in health care.
4. Apply leadership strategies to quality improvement in a health care organization.
5. Communicate in a manner that is scholarly, professional, and respectful of the diversity, dignity, and integrity of others and is consistent with the expectations for health care professionals.

Course Prerequisites

There are no prerequisites for this course.

Syllabus ›› Course Materials

Required

The materials listed below are required to complete the learning activities in this course.

Integrated Materials

Many of your required books are available via the VitalSource Bookshelf link in the courseroom, located in your Course Tools. Registered learners in a Resource Kit program can access these materials using the courseroom link on the Friday before the course start date. Some materials are available only in hard-copy format or by using an access code. For these materials, you will receive an email with further instructions for access. Visit the Course Materials page on Campus for more information.

Book

Youngberg, B. J. (2013). *Patient safety handbook*(2nd ed.). Burlington, MA: Jones & Bartlett Learning. ISBN: 9780763774042.

Library

The following required readings are provided in the Capella University Library or linked directly in this course. To find specific readings by journal or book title, use Journal and Book Locator. Refer to the Journal and Book Locator library guide to learn how to use this tool.

- Allen, G. (2015). Infection prevention: A patient safety imperative for the perioperative setting. *AORN Journal, 101*(5), 508–510.
- Arabi, Y. M., Al Owais, S. M., Al-Attas, K., Alamry, A., Alzahrani, K., Baig, B., . . . Taher, S. (2016). Learning from defects using a comprehensive management system for incident reports in critical care. *Anaesthesia & Intensive Care*, *44*(2), 210–220.
- Barlow, R. D. (2015). Silver Cross spins gold lining into sterile processing operations progress: Tarnish turned to tinsel from team-based performance improvement. *Healthcare Purchasing News*, *39*(5), 10–14.
- Barton, A. J., & Makic, M. B. F. (2015). Technology and patient safety [PDF]. *Clinical Nurse Specialist*, *29*(3), 129–130.
- Berry, J. C., Davis, J. T., Bartman, T., Hafer, C. C., Lieb, L. M., Khan, N., & Brilli, R. J. (2016). Improved safety culture and teamwork climate are associated with decreases in patient harm and hospital mortality across a hospital system [PDF]. *Journal of Patient Safety*.
- Berwick, D. M., Nolan, T. W., & Whittington, J. (2008). The Triple Aim: Care, health and cost. *Health Affairs*, *27*(3), 759–769.
- Blouin, A. S. (2013). High reliability: Truly achieving healthcare quality and safety. *Frontiers of Health Services Management*, *29*(3), 35–40.
- Bubalo, J., Warden, B. A., Wiegel, J. J., Nishida, T., Handel, E., Svoboda, L. M., . . . Edillo, P. N. (2014). Does applying technology throughout the medication use process improve patient safety with antineoplastics? *Journal of Oncology Pharmacy Practice*, *20*(6), 445–460.
- Carroll, C., Flucke, N., Barton, A. J., & Thompson T. L. (2013). The use of dashboards to monitor quality of care [PDF]. *Clinical Nurse Specialist*, *27*(2), 61–62.
- Chassin, M. R., & Loeb, J. M. (2013). High-reliability health care: Getting there from here. *Milbank Quarterly*, *91*(3), 459–490.
- Darbyshire, P., Ralph, N., & Caudle, H. (2015). Nursing's mandate to redefine the sentinel event. *Journal of Clinical Nursing*, *24*(11/12), 1445–1446.
- Ewen, B. M., & Bucher, G. (2013). Root cause analysis: Responding to a sentinel event [PDF]. *Home Healthcare Nurse*, *31*(8), 435–443.
- Ewen, B. M., Combs, R., Popelas, C., & Faraone, G. M. (2012). Chemotherapy in home care: One team's performance improvement journey toward reducing medication errors [PDF]. *Home Healthcare Now*, *30*(1), 28–37.
- Hall, J. T., & Kelly, C. M. (2014). A partnership to enhance outcomes through quality dashboards and action planning. *American Nurse Today, 9*(1), 58–61.
- Hoarle, K. (2015). Risk management poised to grow as healthcare evolves. *Biomedical Instrumentation & Technology*, *49*(6), 433–435.
- Howell, A., Burns, E. M., Bouras, G., Donaldson, L. J., Athanasiou, T., & Darzi, A. (2015). Can patient safety incident reports be used to compare hospital safety? Results from a quantitative analysis of the English National Reporting and Learning System data. *Plos One*, *10*(12).
- Kemper, C., Blackburn, C., Doyle, J. A., & Hyman, D. (2013). Engaging patients and families in system-level improvement: A safety imperative. *Nursing Administration Quarterly, 37*(3), 203–215.

- Leape, L., Berwick, D., Clancy, C., Conway, J., Gluck, P., Guest, J., . . . Isaac, T. (2009). Transforming healthcare: A safety imperative. *Quality and Safety in Health Care*, *18*(6), 424–428.
- Lindstrom, R. L. (2013). Dialogue between physicians, regulatory oversight agencies critical to patient safety. *Ocular Surgery News, 31*(17), 3.
- Mannon, M. (2014). Lean healthcare and quality management: The experience of ThedaCare. *The Quality Management Journal*, *21*(1), 7–10.
- Masternak, R. L. (2012). Engaging staff with team-based performance sharing. *Healthcare Financial Management*, *66*(5), 120–124.
- Millar, R. (2013). Framing quality improvement tools and techniques in healthcare. *Journal of Health Organization and Management, 27*(2), 209–224.
- Miranda, S., Jr., & Olexa, G. A. (2013). Creating a just culture. *Pennsylvania Nurse*, *68*(4), 4–10.
- Reed, J. E., & Card, A. J. (2016). The problem with plan-do-study-act cycles. *BMJ Quality & Safety*, *25*(3),147–152.
- Sanders, P. (2016). Seven strategies for partnering with risk managers. *Nursing Management, 47*(10), 18–19.
- Sarkies, M. N., Bowles, K. A., Skinner, E. H., Mitchell, D., Haas, R., Ho, M., . . . Haines, T. P. (2015). Data collection methods in health services research: Hospital length of stay and discharge destination. *Applied Clinical Informatics*, *6*(1), 96–109.
- Shostek, K. (2014). Risk manager's perspective. *AORN Journal*, *100*(4), 422–423.
- Stevens, M. (2014). Just culture: A fairer way to improve care. *Healthcare Leadership Review*, *33*(7), 8–10.
- Watson, D. S. (2009). Sentinel events. *AORN Journal*, *90*(6), 926–929.
- Weiner, J., Balijepally, V., Tanniru, M., & Bujnowski, A. M. (2015). Integrating strategic and operational decision making using data-driven dashboards: The case of St. Joseph Mercy Oakland Hospital. *Journal of Healthcare Management*, *60*(5), 319–331.
- Wickersham, M. E., & Basey, S. (2016). Is accreditation sufficient? A case study and argument for transparency when government regulatory authority is delegated. *Journal of Health and Human Services Administration, 39*(2), 245–282.
- Wyatt, R. (2017). Building safe, highly reliable organizations: CQO shares words of wisdom. *Biomedical Instrumentation & Technology, 51*(1), 65–69.

External Resource

Please note that URLs change frequently. While the URLs were current when this course was designed, some may no longer be valid. If you cannot access a specific link, contact your instructor for an alternative URL. Permissions for the following links have been either granted or deemed appropriate for educational use at the time of course publication.

- Agency for Healthcare Research and Quality. (2017). About the National Quality Strategy. Retrieved from http://www.ahrq.gov/workingforquality/about/index.html
- Agency for Healthcare Research and Quality. (2017). TalkingQuality. Retrieved from https://www.ahrq.gov/cpi/about/otherwebsites/talkingquality.ahrq.gov/index.html
- Agency for Healthcare Research and Quality. (2018). Race, ethnicity, and language data: Standardization for health care quality improvement. Retrieved from https://www.ahrq.gov/research/findings/final-reports/iomracereport/reldata5.html
- Agency for Healthcare Research and Quality. (n.d.). Guidelines and measures. Retrieved from https://www.ahrq.gov/gam/index.html
- Agency for Healthcare Research and Quality. (n.d.). Plan-Do-Study-Act (PDSA) cycle. Retrieved from http://innovations.ahrq.gov/qualitytools/plan-do-study-act-pdsa-cycle
- Agency for Healthcare Research and Quality. (n.d.). TeamSTEPPS: Team strategies & tools to enhance performance & patient safety. Retrieved from https://www.ahrq.gov/teamstepps/index.html
- American Society for Healthcare Risk Management. (2014). *Serious safety events: A focus on harm classification: Deviation in care as link Getting to Zero* [PDF]. Retrieved from http://www.ashrm.org/pubs/files/white_papers/SSE-2_getting_to_zero-9-30-14.pdf
- American Society for Heathcare Risk Management. (n.d.). *Healthcare risk management: The path forward* [PDF]. Retrieved from http://www.ashrm.org/pubs/files/white_papers/Executive-Summary_Risks-Rewards-Healthcare-Reform_FINAL2.pdf
- Angier, H., Gold, R., Gallia, C., Casciato, A., Tillotson, C. J., Marino, M., . . . DeVoe, J. E. (2014). Variation in outcomes of quality measurement by data source. *Pediatrics*, *133*(6), 1676–1682. Retrieved from http://pediatrics.aappublications.org/content/133/6/e1676
- ASQ. (n.d.). About teams. Retrieved from https://asq.org/quality-resources/teams
- Centers for Disease Control and Prevention. (n.d.). National Healthcare Safety Network (NHSN). Retrieved from https://www.cdc.gov/nhsn/
- Centers for Medicare & Medicaid Services. (n.d.). Partnership for Patients. Retrieved from https://partnershipforpatients.cms.gov/
- HealthyPeople.gov. (n.d.). Leading health indicators. Retrieved from https://www.healthypeople.gov/2020/Leading-Health-Indicators
- Institute for Healthcare Improvement. (n.d.). IHI Triple Aim initiative. Retrieved from http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx
- Institute for Healthcare Improvement. (Producer). (n.d.) *PDSA cycles (part 1)* [Video]. Retrieved from http://www.ihi.org/education/IHIOpenSchool/resources/Pages/AudioandVideo/Whiteboard5.aspx
- Institute for Healthcare Improvement. (Producer). (n.d.). *What is a culture of safety?* [Video]. Retrieved from http://www.ihi.org/education/IHIOpenSchool/resources/Pages/Activities/Bates-What-Is-A-Culture-Of-Safety.aspx
- Joint Commission. (2018). Facts about ORYX for hospitals (national hospital quality measures). Retrieved from https://www.jointcommission.org/facts_about_oryx_for_hospitals/
- Joint Commission. (n.d.). National Patient Safety Goals. Retrieved from https://www.jointcommission.org/standards_information/npsgs.aspx
- Joint Commission. (n.d.). Sentinel event. Retrieved from https://www.jointcommission.org/sentinel_event.aspx
- Leape, L. L. (2011). A blueprint on patient safety. Retrieved from http://archive.boston.com/bostonglobe/editorial_opinion/blogs/the_podium/2011/11/_by_lucian_l_leape.html
- National Quality Forum. (n.d.). Serious reportable events. Retrieved from http://www.qualityforum.org/topics/sres/serious_reportable_events.aspx
- NCQA. (n.d.). HEDIS and performance measurement. Retrieved from https://www.ncqa.org/hedis/

- Singh, B., & Ghatala, M. H. (2012). Risk management in hospitals. *International Journal of Innovation, Management and Technology, 3*(4), 417–421. Retrieved from http://www.ijimt.org/show-38-493-1.html
- U.S. Department of Health and Human Services, Health Resources and Services Administration. (n.d.). *Improvement teams* [PDF]. Retrieved from https://www.hrsa.gov/sites/default/files/quality/toolbox/508pdfs/improvementteams.pdf
- World Health Organization. (2018). 10 facts on patient safety. Retrieved from https://www.who.int/features/factfiles/patient_safety/en/
- World Health Organization. (n.d.). Patient safety. Retrieved from https://www.who.int/patientsafety/en/

Suggested

The following materials are recommended to provide you with a better understanding of the topics in this course. These materials are not required to complete the course, but they are aligned to course activities and assessments and are highly recommended for your use.

Optional

The following optional materials are offered to provide you with a better understanding of the topics in this course. These materials are not required to complete the course.

Library

The following optional readings may be available in the Capella University Library. To find specific readings by journal or book title, use Journal and Book Locator. Refer to the Journal and Book Locator library guide to learn how to use this tool. If the full text is not available, you may be able to request a copy through the Interlibrary Loan service.

- Abel, E. A., Brandt, C. A., Czlapinski, R., & Goulet, J. L. (2016). Pain research using Veterans Health Administration electronic and administrative data sources. *Journal of Rehabilitation Research and Development*, *53*(1), 1–11.
- Encinosa, W. E., & Bae, J. (2012). Health information technology and its effects on hospital costs, outcomes, and patient safety [PDF]. *Inquiry – Excellus Health Plan*, *48*(4), 288–303.
- Fracasso, M. R., & Sanders, B. (2012). Two keys to deliver better care and measure quality: Pod implementation & dashboards. *Physician Executive*, *38*(6), 48–52, 54.
- Frank-Cooper, M. (2014). The justice behind a just culture. *Nephrology Nursing Journal*, *41*(1), 87–88.
- Khalamayzer, A. (2012, May 10). An apple a day won't keep risks at bay, but these RMs do. *The National Underwriter.*
- Kilpeläinen, K., Parikka, S., Koponen, P., Koskinen, S., Rotko, T., Koskela, T., & Gissler, M. (2016). Finnish experiences of health monitoring: Local, regional, and national data sources for policy evaluation. *Global Health Action*, *9*.
- Kovach, J. V., Revere, L., & Black, K. (2013). Error proofing healthcare: An analysis of low cost, easy to implement and effective solutions. *Leadership in Health Services*, *26*(2), 107–117.
- Pratt, N. (2014). Quality officer takes on patient safety challenges. *Biomedical Instrumentation & Technology, 48*(4), 277–280.
- Staff. (2013). 6 ways to improve your root cause analysis. *Healthcare Risk Management*, 35(7).
- Surprise, J. K., & Simpson, M. H. (2015). One hospital's initiatives to encourage safe opioid use. *Journal of Infusion Nursing, 38*(4), 278–283.

External Resource

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- Botwinick, L., Bisognano, M., & Haraden, C. (2006). Leadership guide to patient safety. Retrieved from http://www.ihi.org/resources/Pages/IHIWhitePapers/LeadershipGuidetoPatientSafetyWhitePaper.aspx
- Centers for Medicare & Medicaid Services. (n.d.). *PDSA cycle template* [PDF]. Retrieved from https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/PDSACycledebedits.pdf
- Institute for Healthcare Improvement. (n.d.). Plan-Do-Study-Act (PDSA) worksheet. Retrieved from http://www.ihi.org/resources/Pages/Tools/PlanDoStudyActWorksheet.aspx
- Institute for Safe Medication Practices. (2010). Building patient safety skills: Common pitfalls when conducting a root cause analysis. Retrieved from https://www.ismp.org/resources/building-patient-safety-skills-common-pitfalls-when-conducting-root-cause-analysis
- Kohn, L. T., Corrigan, J. M., & Donaldson, M. S. (Eds.). (1999). *To err is human: Building a safer health system.* Washington, DC: National Academy Press. Retrieved from https://www.nap.edu/catalog/9728/to-err-is-human-building-a-safer-health-system
- Mitchell, P. H. (2008). Defining patient safety and quality care. In R. G. Hughes (Ed.), *Patient safety and quality: An evidence-based handbook for nurses*. Rockville, MD: Agency for Healthcare Research and Quality. Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK2681/
- National Association for Healthcare Quality. (2018). *NAHQ code of ethics for healthcare quality professionals and code of conduct.* Retrieved from https://nahq.org/about/code-of-ethics
- Patient Safety Movement. (n.d.). Retrieved from https://patientsafetymovement.org/

- Patient Safety Movement. (Producer). (n.d.). *Emily Jerry* [Video]. | Transcript Retrieved from https://patientsafetymovement.org/advocacy/patients-and-families/patient-stories/emily-jerry/
- Reinertsen, J. L., Bisognano, M., & Pugh, M. D. (2008). *Seven leadership leverage points for organization-level improvement in health care* (2nd. ed). Cambridge, MA: Institute for Healthcare Improvement. Retrieved from http://www.ihi.org/resources/Pages/IHIWhitePapers/SevenLeadershipLeveragePointsWhitePaper.aspx

Unit 1 >> Introduction to Health Care Quality, Patient Safety, and Performance Improvement

Introduction

Health care is complex and at times confusing to consumers. Introduced by the Institute for Healthcare Improvement (IHI), the Triple Aim consists of three approaches to optimizing health system performance: ensure quality of care for the individual, improve the health of the population, and control costs (Beaudin & Pelletier, 2012). Everyone from practitioners and health systems to insurers, employers, and government agencies seek ways to achieve the Triple Aim; however, developing, deploying, and sustaining appropriate quality strategies poses challenges and creates opportunities for health care leaders.

"Eliminating medical errors is an urgent imperative in the health care industry" (Beaudin & Pelletier, 2012, p. 1). Covering all health care settings, health care safety includes the patient and staff experience as well as the clinical, environmental, and services aspects of safety (Beaudin & Pelletier, 2012). Accreditation and regulatory agencies, such as the Joint Commission, the National Committee for Quality Assurance (NCQA), and the Centers for Medicare and Medicaid Services (CMS), are championing the movement to reduce errors. As an example of efforts toward eliminating medical errors, the Joint Commission developed the National Patient Safety Goals (NPSGs) in 2003, to identify and call attention to areas in need of attention and improvement.

Regardless of your role within the health care organization, a basic understanding of health care safety, performance improvement, risk management, and quality is critical for keeping patients, visitors, and employees safe.

Reference

Beaudin, C. L., & Pelletier, L. R. (2012). *Essential resources for the healthcare quality professional: Healthcare safety* (3rd ed.). Glenview, IL: National Association of Healthcare Quality.

Learning Activities

u01s1 - Studies

Readings

Use your *Patient Safety Handbook* text to read the following:

- Chapter 1, "Understanding the First Institute of Medicine Report and Its Impact on Patient Safety," pages 1–16.
- Chapter 2, "Patient Safety Movement: The Progress and the Work That Remains," pages 17–28.
- Chapter 3, "Accelerating Patient Safety Improvement," pages 29–38.

Use the Capella University Library to read the following:

- Leape, L., Berwick, D., Clancy, C., Conway, J., Gluck, P., Guest, J., . . . Isaac, T. (2009). Transforming healthcare: A safety imperative. *Quality and Safety in Health Care*, *18*(6), 424–428.

Use the Internet to read the following:

- World Health Organization. (n.d.). Patient safety. Retrieved from https://www.who.int/patientsafety/en/
- World Health Organization. (2018). 10 facts on patient safety. Retrieved from https://www.who.int/features/factfiles/patient_safety/en/
- Agency for Healthcare Research and Quality. (2017). About the National Quality Strategy. Retrieved from http://www.ahrq.gov/workingforquality/about/index.html
- Institute for Healthcare Improvement. (n.d.). IHI Triple Aim initiative. Retrieved from http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx
- Joint Commission. (n.d.). National Patient Safety Goals. Retrieved from https://www.jointcommission.org/standards_information/npsgs.aspx

Optional Readings

You may choose to read the following optional materials to further your understanding of the topics in this unit:

- Berwick, D. M., Nolan, T. W., & Whittington, J. (2008). The Triple Aim: Care, health and cost. *Health Affairs*, *27*(3), 759–769.

- Blouin, A. S. (2013). High reliability: Truly achieving healthcare quality and safety. *Frontiers of Health Services Management*, *29*(3), 35–40.
- Mitchell, P. H. (2008). Defining patient safety and quality care. In R. G. Hughes (Ed.), *Patient safety and quality: An evidence-based handbook for nurses*. Rockville, MD: Agency for Healthcare Research and Quality. Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK2681/
    - Read Chapter 1.

u01s2 - Assignment Preparation

In Unit 2, you will submit your first of four written assignments. In this assignment, you will analyze the health care safety imperative and the importance of the patient safety program in health care organizations.

Review the Addressing a Patient Safety Issue assignment instructions and scoring guide to learn more about the assignment expectations. You should begin working on this assignment now by researching the relevant topics. Search topics might include:

- Errors in health care.
- Health care safety imperative.
- Regulatory agency oversight.
- Patient safety program.
- Patient safety officer.
- Common tools used in patient safety programs.

Take some time in this unit to read or review the required and optional materials for completing this assignment.

Readings

Use the Capella library to read or review the following:

- Allen, G. (2015). Infection prevention: A patient safety imperative for the perioperative setting. *AORN Journal, 101*(5), 508–510.
- Berwick, D. M., Nolan, T. W., & Whittington, J. (2008). The Triple Aim: Care, health and cost. *Health Affairs*, *27*(3), 759–769.
- Blouin, A. S. (2013). High reliability: Truly achieving healthcare quality and safety. *Frontiers of Health Services Management*, *29*(3), 35–40.
- Kemper, C., Blackburn, C., Doyle, J. A., & Hyman, D. (2013). Engaging patients and families in system-level improvement: A safety imperative. *Nursing Administration Quarterly, 37*(3), 203–215.
- Leape, L., Berwick, D., Clancy, C., Conway, J., Gluck, P., Guest, J., . . . Isaac, T. (2009). Transforming healthcare: A safety imperative. *Quality and Safety in Health Care*, *18*(6), 424–428.
- Wickersham, M. E., & Basey, S. (2016). Is accreditation sufficient? A case study and argument for transparency when government regulatory authority is delegated. *Journal of Health and Human Services Administration, 39*(2), 245–282.
- Wyatt, R. (2017). Building safe, highly reliable organizations: CQO shares words of wisdom. *Biomedical Instrumentation & Technology, 51*(1), 65–69.

Use the Internet to read or review the following:

- Agency for Healthcare Research and Quality. (2017). About the National Quality Strategy. Retrieved from http://www.ahrq.gov/workingforquality/about/index.html
- Agency for Healthcare Research and Quality. (n.d.). TeamSTEPPS: Team strategies & tools to enhance performance & patient safety. Retrieved from https://www.ahrq.gov/teamstepps/index.html
- National Quality Forum. (n.d.). Serious reportable events. Retrieved from http://www.qualityforum.org/topics/sres/serious_reportable_events.aspx

Vila Health

Complete the following Vila Health simulation:

- Click **Vila Health: Patient Safety** to assess your knowledge of the health care regulations that govern patient safety and of a health care leader's role and responsibility in ensuring patient safety. This information will help prepare you to successfully complete your Unit 2 assignment, which will require you to prepare a recommendation for leadership about how to address a specific threat to patient safety.

Optional Readings

The following resources will be helpful in preparing for the Unit 2 assignment. Choose those that are most appropriate for your work.

The Safety Imperative

You may read, review, or view the following:

- Pratt, N. (2014). Quality officer takes on patient safety challenges. *Biomedical Instrumentation & Technology, 48*(4), 277–280.
- Botwinick, L., Bisognano, M., & Haraden, C. (2006). Leadership guide to patient safety. Retrieved from http://www.ihi.org/resources/Pages/IHIWhitePapers/LeadershipGuidetoPatientSafetyWhitePaper.aspx
  - **Note**: You will need to register with the IHI to read this white paper. The registration is free.
- Institute for Healthcare Improvement. (n.d.). IHI Triple Aim initiative. Retrieved from http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx
- Kohn, L. T., Corrigan, J. M., & Donaldson, M. S. (Eds.). (1999). *To err is human: Building a safer health system*. Washington, DC: National Academy Press. Retrieved from https://www.nap.edu/catalog/9728/to-err-is-human-building-a-safer-health-system
- Patient Safety Movement. (n.d.). Retrieved from https://patientsafetymovement.org/
- Patient Safety Movement. (Producer). (n.d.). *Emily Jerry* [Video] | Transcript. Retrieved from https://patientsafetymovement.org/advocacy/patients-and-families/patient-stories/emily-jerry/

Regulatory Agencies

You may read or review the following:

- Joint Commission. (n.d.). National Patient Safety Goals. Retrieved from https://www.jointcommission.org/standards_information/npsgs.aspx
- Joint Commission. (n.d.). Sentinel event. Retrieved from https://www.jointcommission.org/sentinel_event.aspx

Regulatory Oversight

You may review the following:

- Lindstrom, R. L. (2013). Dialogue between physicians, regulatory oversight agencies critical to patient safety. *Ocular Surgery News, 31*(17), 3.

Tools, Operational Considerations, and Best Practices to Address Safety Threats

You may review the following:

- Arabi, Y. M., Al Owais, S. M., Al-Attas, K., Alamry, A., Alzahrani, K., Baig, B., . . . Taher, S. (2016). Learning from defects using a comprehensive management system for incident reports in critical care. *Anaesthesia & Intensive Care*, *44*(2), 210–220.
- Howell, A., Burns, E. M., Bouras, G., Donaldson, L. J., Athanasiou, T., & Darzi, A. (2015). Can patient safety incident reports be used to compare hospital safety? Results from a quantitative analysis of the English National Reporting and Learning System data. *Plos One*, *10*(12).

Course Resources

Vila Health: Patient Safety

u01d1 - The Triple Aim

As the manager of your hospital's quality department, you have been asked to work with various stakeholders to improve the health of the population served by your organization. You decide to begin by introducing the Triple Aim to your work group.

In your post:

- Describe the Triple Aim as outlined by the IHI:
  - Describe the purpose of the model.
  - Identify and explain the three elements of the Triple Aim model.
- Provide an example of how this model can be used as a framework to address one of the following conditions:
  - Pediatric asthma.
  - Hypertension.
  - Diabetes.

You may also select your own population health issue to apply to this model.

As you write your post and responses, remember to cite your sources using current APA style.

Response Guidelines

As noted in the Faculty Expectations message (FEM), provide substantive comments to your peers, comparing his or her perspective to yours. Ask any questions that will help you better understand your peer's perspective.

Course Resources
Undergraduate Discussion Participation Scoring Guide
APA Module
Health Care Administration Undergraduate Library Research Guide

u01d1 - Learning Components

- Explain the purpose of the Triple Aim as outlined by the Institute for Healthcare Improvement.
- Analyze the importance of patient safety in health care.
- Analyze the health care safety imperative.

u01d2 - National Patient Safety Goals

The groundbreaking report, *To Err Is Human*, provided alarming data regarding the impact of medical errors in health care. Many health care organizations are actively working toward improving the quality and safety of care provided to their patients through various programs and initiatives.

For this discussion, research the Joint Commission's NPSGs. Choose a health care setting from the 2019 NPSG Program Links on the web page. Follow the link and read through the goals related to that setting. Choose one of the goals to build your discussion around. In your post, explain why the goal is important, what its purpose is, and why you feel it should be a targeted area for improvement.

Cite your sources using current APA style.

Response Guidelines

As noted in the FEM, provide substantive comments to your peers, comparing his or her perspective to yours. Ask any questions that will help you better understand your peer's perspective.

Course Resources
Undergraduate Discussion Participation Scoring Guide
APA Module
Health Care Administration Undergraduate Library Research Guide
National Patient Safety Goals
To Err Is Human

u01d2 - Learning Components

- Analyze the importance of patient safety in health care.
- Analyze the health care safety imperative.

Unit 2 >> Patient Safety

Introduction

Alarming numbers of unnecessary patient deaths occur in U.S. hospitals and around the world. "Quality and patient safety in health care have been on the forefront of the public's mind since the publication of the Institute of Medicine's (IOM) seminal report, *To Err Is Human*, in 1999" (Johnson, Haskell, & Barach, 2016, p. xv). The literature supports revising systems and processes in an effort to narrow the difficult safety and quality gaps. Of course, health care professionals, who deliver services in our systems of care, are also of critical importance to the future of health care improvement and patient and population outcomes (Johnson, Haskell, & Barach, 2016).

The IOM report generated a new movement of organizations that focus on patient safety. The federal Agency for Healthcare Research and Quality (AHRQ), established in 2000 by the U.S. Congress, became the largest funding source for patient safety research. In addition to the federal government, the private sector became involved as well. The federal government's decision to decrease or refuse payment due to poor patient outcomes resulted in the industry altering its view on patient safety. Errors were defined, and efforts were initiated to reduce and eliminate patient errors. As an example, in 2002, the National Quality Forum defined a *never event* as a serious reportable event, such as surgery on the wrong body part. The CMS went further and defined the *never event* as a non-reimbursable, serious hospital-acquired condition.

As noted in Unit 1, the Joint Commission developed the NPSGs in 2003. The Joint Commission uses the term *sentinel event*, which is a safety event that reaches a patient and results in death, permanent harm, or severe temporary harm with intervention required to sustain life (Joint Commission, 2017). Sentinel events require immediate investigation and response (Youngberg, 2013). Other initiatives include Safe Practices for Better Healthcare, the Patient Safety and Quality Improvement Act, and the Partnership for Patients program.

Worldwide, health care reform is driven by issues of patient safety and patient-centered quality care. However, current approaches are not yet adequate, thus patients remain at risk for needless harm.

References

Johnson, J. K., Haskell, H. W., & Barach, P. R. (2016). *Case studies in patient safety*. Burlington, MA: Jones & Bartlett Learning.

Joint Commission. (2017). Sentinel event policy and procedures. Retrieved from https://www.jointcommission.org/sentinel_event_policy_and_procedures/

Youngberg, B. J. (2013). *Patient safety handbook* (2nd ed.). Burlington, MA: Jones and Bartlett Learning.

Learning Activities

u02s1 - Studies

Readings

Use your *Patient Safety Handbook* text to read the following:

- Chapter 7, "Toward a Philosophy of Patient Safety: Expanding the Systems Approach to Medical Error," pages 87–97.
- Chapter 23, "Health Information Technology and Patient Safety," pages 291–297.

Use the Capella library to read or review the following:

- Allen, G. (2015). Infection prevention: A patient safety imperative for the perioperative setting. *AORN Journal, 101*(5), 508–510.
- Darbyshire, P., Ralph, N., & Caudle, H. (2015). Nursing's mandate to redefine the sentinel event. *Journal of Clinical Nursing*, *24*(11/12), 1445–1446.
- Barton, A. J., & Makic, M. B. F. (2015). Technology and patient safety [PDF]. *Clinical Nurse Specialist*, *29*(3), 129–130.
- Bubalo, J., Warden, B. A., Wiegel, J. J., Nishida, T., Handel, E., Svoboda, L. M., . . . Edillo, P. N. (2014). Does applying technology throughout the medication use process improve patient safety with antineoplastics? *Journal of Oncology Pharmacy Practice*, *20*(6), 445–460.
- Kemper, C., Blackburn, C., Doyle, J. A., & Hyman, D. (2013). Engaging patients and families in system-level improvement: A safety imperative. *Nursing Administration Quarterly, 37*(3), 203–215.
- Lindstrom, R. L. (2013). Dialogue between physicians, regulatory oversight agencies critical to patient safety. *Ocular Surgery News, 31*(17), 3.
- Wickersham, M. E., & Basey, S. (2016). Is accreditation sufficient? A case study and argument for transparency when government regulatory authority is delegated. *Journal of Health and Human Services Administration, 39*(2), 245–282.

Vila Health

Complete the following Vila Health simulation:

- Click **Vila Health: Patient Safety** to assess your knowledge of the health care regulations that govern patient safety and of a health care leader's role and responsibility in ensuring patient safety. This information will help prepare you to successfully complete your first assignment, due in this unit, which will require you to prepare a recommendation for leadership about how to address a specific threat to patient safety.

Optional Readings

You may choose to read the following optional materials to further your understanding of the topics in this unit:

- Encinosa, W. E., & Bae, J. (2012). Health information technology and its effects on hospital costs, outcomes, and patient safety. *Inquiry – Excellus Health Plan*, *48*(4), 288–303.
- Watson, D. S. (2009). Sentinel events. *AORN Journal*, *90*(6), 926–929.

Assignment Preparation

Refer back to the Assignment Preparation reading materials provided in Unit 1 as you prepare to submit the assignment due in this unit.

Course Resources

Vila Health: Patient Safety

u02a1 - Addressing a Patient Safety Issue

Introduction

Alarming numbers of unnecessary patient deaths occur in U.S. hospitals and around the world. "Quality and patient safety in health care have been on the forefront of the public's mind since the publication of the Institute of Medicine's (IOM) seminal report, 'To Err Is Human,' in 1999" (Johnson, Haskell, & Barach, 2016, pg. xv). The literature supports revising systems and processes in an effort to narrow the difficult safety and quality gaps. Worldwide, issues of patient safety and patient-centered quality care drive health care reform. Current approaches are not adequate; patients remain at risk for needless harm.

Demonstrating a firm understanding of the various components of patient safety is fundamental to understanding health care quality, risk management, and patient safety overall.

For this first assignment, you will assume the role of a patient safety officer at your local hospital. You will analyze a patient safety issue that occurred and then prepare a 5–7-page recommendation for senior leaders about why it is important to address the issue, along with your recommendations about how to address it. You will also need to detail the role you, as the patient safety officer, will play in helping the organization resolve the issue.

Demonstration of Proficiency

By successfully completing this assignment, you will demonstrate proficiency in the following course competencies. Refer to the scoring guide for further details.

- Competency 1: Analyze the quality and performance improvement activities within the health care organization.
- Competency 3: Analyze the importance of patient safety in health care.
- Competency 4: Apply leadership strategies to quality improvement in a health care organization.
- Competency 5: Communicate in a manner that is scholarly, professional, and respectful of the diversity, dignity, and integrity of others and is consistent with the expectations for health care professionals.

Summary

Write a 5–7-page recommendation to senior leadership about steps the organization needs to take to resolve a patient safety issue that occurred. Include an explanation of why it is important to address the issue and the role the patient safety officer will play in helping to resolve the issue.

Preparation

To successfully complete this assignment:

- Select one of the three scenarios from the Vila Health: Patient Safety simulation that interests you the most for further analysis in your assignment:
  - Scenario 1: Patient Identification Error.
  - Scenario 2: Medication Error.
  - Scenario 3: HIPAA/Privacy Violation.
- Consult the readings listed in the assignment preparation study in Unit 1.

- Review the Assignment 1 template (provided in the resources) which you will use to complete this assignment. This document is formatted and has space for completing all components of the assignment.

Instructions

For the scenario you selected, write a 5–7-page recommendation for leadership that describes the safety threat, the importance of addressing the threat, and your recommendations for resolving it. Be sure to include all of the following in your paper and to address all of the points:

- Apply the health care safety imperative to a patient safety issue.
  - Identify the issue you selected from the Vila Health simulation as the potential safety threat.
  - Describe the issue that occurred with sufficient detail so that leadership has a clear understanding of what happened.
  - Identify the implications of not addressing threat.
- Evaluate the risk to the patients, employees, and organization, if patient safety threats are not addressed.
  - What does the health care safety imperative say about the issue?
  - How does the health care safety imperative apply in this case?
  - Which regulatory agencies have oversight about the issue?
- Analyze regulatory agencies' role and impact on organizations' patient safety programs.
  - What specifically do the regulations state about the issue? For example, you might consider the Joint Commission's NPSGs.
  - What impact do regulatory agencies have on organizations' patient safety programs?
  - How do health care organizations incorporate regulatory agencies' guidance when establishing reporting and investigation best practices?
  - What are the potential consequences to the patients, employees, and organization, if the hospital fails to correct the threat?
- Analyze the patient safety officer's role in implementing patient safety plans.
  - Explain the role patient safety officers assume in implementing patient safety plans in health care organizations.
  - Clarify your responsibility and role as the patient safety officer in this specific instance.
  - Provide one example from the literature to illustrate your points.
- Recommend evidence-based best practice tools and techniques to reduce or eliminate patient safety threats.
  - Describe your five-point plan to reduce or eliminate this patient safety threat.
    - What best practice tools or techniques does your plan include to reduce or eliminate these types of errors? Consider processes for responding, rounding, detecting, incident reporting, operational considerations, et cetera.

In a health care professional setting, recommendations to leadership would typically not be in APA format. However, your paper does need to conform to current APA format and style guidelines. It does need to be clear, persuasive, organized, and well written without spelling, grammar, and/or punctuation errors. In addition, recommendations you write in a professional setting would be single-spaced. For the purpose of this assignment, however, please use double-spacing.

Also, health care is an evidence-based field. Your senior leaders will want to know the sources of your information, so be sure to include at least two peer-reviewed sources. You may use the suggested resources for this assignment. Your citations and references do need to conform to current APA guidelines.

Please review the Addressing a Patient Safety Issue Scoring Guide to ensure you understand the grading requirements for this assignment.

Additional Requirements

Your assignment should also meet the following requirements:

- **Template**: Use the Assignment 1 template (provided in the resources) to complete this assignment.
- **Length**: 5–7 double-spaced pages, not including title and reference pages.
- **Font and font size**: Times New Roman, 12 point.
- **APA format**: Your submission, including the body, citations, and title and references pages need to conform to current APA format and style guidelines. Do make sure that it is clear, persuasive, organized, and well written, without grammatical, punctuation, or spelling errors. You also must cite your sources according to current APA guidelines.

Reference

Johnson, J. K., Haskell, H. W., & Barach, P. R. (2016). *Case studies in patient safety*. Burlington, MA: Jones & Bartlett Learning.

Course Resources

APA Module

APA Style and Format

APA Style Paper Tutorial [DOCX]

Health Care Administration Undergraduate Library Research Guide

Assignment 1 Template [DOC]

Vila Health: Patient Safety | Transcript

u02d1 - Near Misses and Sentinel Events

Errors in health care range from potential errors to patient death. For this discussion, explain the differences between near misses and sentinel events. Provide an example of each, and outline an appropriate organizational response.

Cite your sources using current APA style.

Response Guidelines

As noted in the FEM, provide substantive comments to your peers, comparing his or her perspective to yours. Ask any questions that will help you better understand your peer's perspective.

Course Resources

Undergraduate Discussion Participation Scoring Guide

APA Module

Health Care Administration Undergraduate Library Research Guide

u02d1 - Learning Components

- Define near misses and sentinel events.
- Describe the appropriate organizational response for near misses and sentinel events.

Unit 3 >> Risk Management

Introduction

Health care organizations have always searched for ways to identify and reduce risks. The current practices of health care risk management were developed in the mid-1970s, when a surge in malpractice suits caused rapid increases in claims costs for the industry, and later in insurance premiums. It was during this time that several major medical professional liability insurers exited from the market as well. This crisis resulted in many health care entities developing their first risk management programs (Carroll, 2009).

The new focus on risk management among health care organizations resulted in the establishment of the American Society for Healthcare Risk Management (ASHRM) in 1980. "Over the years, health care risk management has moved from a discipline focused almost exclusively on medical professional liability issues to a profession concerned with all of the risks associated with accidental losses facing a health care organization" (Carroll, 2009, p. 2).

All health care delivery systems and organizations now realize the value of risk management and have developed formalized programs (Carroll, 2009). In addition, organizations should have established mechanisms for reviewing potential incidents of risk and safety concerns (Beaudin & Pelletier, 2012). While the risk management program is tasked with daily management and risk operations, it is the responsibility of all health care stakeholders to participate in activities that will reduce unnecessary risks and improve safety and quality (Carroll, 2009).

References

Beaudin, C. L., & Pelletier, L. R. (2012). *Essential resources for the healthcare quality professional: Healthcare safety* (3rd ed.). Glenview, IL: National Association of Healthcare Quality.

Carroll, R. A. (2009). *Risk management handbook for health care organizations.* San Francisco, CA: Jossey-Bass.

Learning Activities

u03s1 - Studies

Readings

Use your *Patient Safety Handbook* text to read the following:

- Chapter 9, "The Investigation and Analysis of Clinical Incidents," pages 111–122.
- Chapter 17, "The Role of the Risk Manager in Creating Patient Safety," pages 217–224.

Use the Capella library to read the following:

- Ewen, B. M., & Bucher, G. (2013). Root cause analysis: Responding to a sentinel event [PDF]. *Home Healthcare Nurse*, *31*(8), 435–443.
- Hoarle, K. (2015). Risk management poised to grow as healthcare evolves. *Biomedical Instrumentation & Technology*, *49*(6), 433–435.
- Shostek, K. (2014). Risk manager's perspective. *AORN Journal*, *100*(4), 422–423.

Use the Internet to read the following:

- Singh, B., & Ghatala, M. H. (2012). Risk management in hospitals. *International Journal of Innovation, Management and Technology, 3*(4), 417–421. Retrieved from http://www.ijimt.org/show-38-493-1.html

Multimedia

Complete the following Capella multimedia presentation:

- Risk Management and Patient Safety: Drag and Drop.
  - This media will help test your knowledge of the topic.

Optional Readings

You may choose to read the following optional materials to further your understanding of the topics in this unit:

- Khalamayzer, A. (2012, May 10). An apple a day won't keep risks at bay, but these RMs do. *The National Underwriter.*
- Staff. (2013). 6 ways to improve your root cause analysis. *Healthcare Risk Management*, 35(7).
- Institute for Safe Medication Practices. (2010). Building patient safety skills: Common pitfalls when conducting a root cause analysis. Retrieved from https://www.ismp.org/resources/building-patient-safety-skills-common-pitfalls-when-conducting-root-cause-analysis

u03s2 - Assignment Preparation

In Unit 4, you will submit your second assignment, which focuses on risk management. If you have not already started working on the assignment, begin now by researching the relevant topics. You will want to research the following:

- Risk categories in health care.
- Health care risk management program.
- Risk identification techniques.
- The role of risk manager.

Review the Risk Management Policy and Procedure assignment description and scoring guide to learn more about the assignment expectations. Also, take time to read or review the required and optional readings for completing this assignment.

Readings

Use the Capella library to read or review the following:

- Arabi, Y. M., Al Owais, S. M., Al-Attas, K., Alamry, A., Alzahrani, K., Baig, B., . . . Taher, S. (2016). Learning from defects using a comprehensive management system for incident reports in critical care. *Anaesthesia & Intensive Care*, *44*(2), 210–220.
- Darbyshire, P., Ralph, N., & Caudle, H. (2015). Nursing's mandate to redefine the sentinel event. *Journal of Clinical Nursing*, *24*(11/12), 1445–1446.

- Howell, A., Burns, E. M., Bouras, G., Donaldson, L. J., Athanasiou, T., & Darzi, A. (2015). Can patient safety incident reports be used to compare hospital safety? Results from a quantitative analysis of the English National Reporting and Learning System data. *Plos One*, *10*(12).
- Sanders, P. (2016). Seven strategies for partnering with risk managers. *Nursing Management, 47*(10), 18–19.
- Watson, D. S. (2009). Sentinel events. *AORN Journal*, *90*(6), 926–929.

Use the Internet to read or review the following:

- American Society for Heathcare Risk Management. (n.d.). *Healthcare risk management: The path forward* [PDF]. Retrieved from http://www.ashrm.org/pubs/files/white_papers/Executive-Summary_Risks-Rewards-Healthcare-Reform_FINAL2.pdf
- American Society for Healthcare Risk Management. (2014). *Serious safety events: A focus on harm classification: Deviation in care as link Getting to Zero* [PDF]. Retrieved from http://www.ashrm.org/pubs/files/white_papers/SSE-2_getting_to_zero-9-30-14.pdf
- Joint Commission. (n.d.). Sentinel event. Retrieved from https://www.jointcommission.org/sentinel_event.aspx

Optional Readings

The following resources will be helpful in completing the Unit 4 assignment. Choose those that are appropriate for your work.

Risk Events

You may read or review the following:

- Ewen, B. M., & Bucher, G. (2013). Root cause analysis: Responding to a sentinel event. *Home Healthcare Nurse*, *31*(8), 435–443.
- Surprise, J. K., & Simpson, M. H. (2015). One hospital's initiatives to encourage safe opioid use. *Journal of Infusion Nursing, 38*(4), 278–283.

Risk Identification

You may review the following:

- Staff. (2013). 6 ways to improve your root cause analysis. *Healthcare Risk Management*, 35(7).

Risk Manager

You may review the following:

- Shostek, K. (2014). Risk manager's perspective. *AORN Journal*, *100*(4), 422–423.

u03d1 - The Health Care Risk Manager

To be effective, every risk management program is encouraged to have a risk manager with varying roles and responsibilities, depending upon the organization's size and services.

In your post:

- Define the role of the health care risk manager.
- Choose two different types of organizations and compare and contrast how the role might differ between the two.

Cite your sources using current APA style.

Response Guidelines

As noted in the FEM, provide substantive comments to your peers, comparing his or her perspective to yours. Ask any questions that will help you better understand your peer's perspective.

Course Resources
Undergraduate Discussion Participation Scoring Guide
APA Module
Health Care Administration Undergraduate Library Research Guide

u03d1 - Learning Components

- Describe the role of a health care risk manager.
- Explain the importance of an organization's risk management program to risk prevention, risk reduction, regulatory compliance, and patient safety.

u03d2 - Risk Management Plans

It is recommended that health care organizations have a risk management program in place. In your post:

- Analyze the importance of the health care organization's risk management plan.
  - What elements are included?
  - What categories of risk does it typically address?
  - What are the implications of having no risk management plan?
- Provide examples to support your discussion.

Cite your sources using current APA style.

Response Guidelines

As noted in the FEM, provide substantive comments to your peers, comparing his or her perspective to yours. Ask any questions that will help you better understand your peer's perspective.

Course Resources
Undergraduate Discussion Participation Scoring Guide
APA Module
Health Care Administration Undergraduate Library Research Guide

u03d2 - Learning Components

- Analyze the importance of a health care organization’s risk management program.

Unit 4 >> Risk Mitigation, Quality Improvement, and Performance Improvement

Introduction

An organization's ability to identify and analyze its risk exposure is a determining factor in the effectiveness of its risk management program (Carroll, 2009). Early identification and analysis have been found to be essential. The Insurance Institute of America, supported by the ASHRM, has developed a five-step decision-making process for use by risk management professionals. The principles of risk identification and analysis are suitable for use in any care setting and with all programs, regardless of scope or size (Carroll, 2009).

Reference

Carroll, R. A. (2009). *Risk management handbook for health care organizations.* San Francisco, CA: Jossey-Bass.

Learning Activities

u04s1 - Studies

Readings

Use your *Patient Safety Handbook* text to read the following:

- Chapter 26, "Patient Handoffs—Perils and Opportunities," pages 323–332.
- Chapter 28, "Identifying and Addressing Physicians at High Risk for Medical Malpractice Claims," pages 347–368.

- Chapter 29, "Medical Malpractice Litigation: Conventional Wisdom Versus Reality," pages 369–380.

Use the Capella library to review the following:

- Arabi, Y. M., Al Owais, S. M., Al-Attas, K., Alamry, A., Alzahrani, K., Baig, B., . . . Taher, S. (2016). Learning from defects using a comprehensive management system for incident reports in critical care. *Anaesthesia & Intensive Care*, *44*(2), 210–220.
- Howell, A., Burns, E. M., Bouras, G., Donaldson, L. J., Athanasiou, T., & Darzi, A. (2015). Can patient safety incident reports be used to compare hospital safety? Results from a quantitative analysis of the English National Reporting and Learning System data. *Plos One*, *10*(12).

Multimedia

Complete the following Capella multimedia presentation:

- All Things Risk.
    - This media will give you an opportunity to assess your knowledge of risk management terminology, including risk categories, risk identification techniques, and risk reporting tools. Mastery of risk management terminology will prove useful as you complete both parts of the assignment in this unit. First, you will write an organizational risk management policy and procedure. Second, you will apply your risk management knowledge to a specific organizational risk that has occurred.

u04a1 - Risk Management Policy and Procedure

Introduction

Health care organizations have always searched for ways to identify and reduce risks. An organization's ability to identify and analyze its risk exposure is a determining factor in the effectiveness of its risk management program (Hoarle, 2015). Early identification and analysis are essential.

Current health care risk management practices developed in the mid-1970s as a result of a surge in malpractice suits. These suits caused rapid increases in claims costs for the industry, and later in insurance premiums. Today, health care delivery systems and organizations realize the value of risk management and have developed formalized programs (Hoarle, 2015). In addition, organizations have established mechanisms to review potential incidents of risk and safety concerns (Pelletier & Beaudin, 2018). While risk management programs are responsible for daily management and risk operations, all health care stakeholders are responsible to participate in activities that will reduce unnecessary risks and improve safety and quality (Hoarle, 2015).

This second assignment consists of two parts. You are to assume the role of a new risk manager within your organization's risk management department. According to your director, employees lack awareness of the organization's risk management program. Likewise, departments inconsistently apply risk management principles. As a result of these deficiencies, your director has given you your first assignment.

Part 1: Risk Management Policy and Procedure

Your director has asked you to write a formal risk management policy and procedure for the organization.

Part 2: Application of Risk Management Principles to a Specific Incident

In addition to the policy and procedure, your director has asked you to apply your knowledge of risk management principles to a specific organizational risk that has occurred. You will select one of the three incidents from the Vila Health: Patient Safety simulation. These incidents included a patient identification error, a medication error, and a HIPAA/privacy violation. Select the risk that holds the most interest for you.

Your director believes that the organization's newly written risk management policy and procedure, coupled with your analysis from a risk management standpoint of a recent, specific incident that occurred, will help employees (and the organization) recognize how the hospital's risk management program contributes to the overall organization's safety and quality improvement efforts.

Demonstration of Proficiency

By successfully completing this assignment, you will demonstrate proficiency in the following course competencies. Refer to the scoring guide for further details.

- Competency 1: Analyze the quality and performance improvement activities within the health care organization.
- Competency 2: Explain the risk management function in the health care organization.
- Competency 4: Apply leadership strategies to quality improvement in a health care organization.
- Competency 5: Communicate in a manner that is scholarly, professional, and respectful of the diversity, dignity, and integrity of others and is consistent with the expectations for health care professionals.

Summary

Write a 3–4-page risk management policy and procedure for a health care organization. Analyze a specific issue that occurred in a health care organization and apply risk management best practices to it for the purpose of early risk identification and risk reduction or elimination in the future.

Preparation

To successfully complete this assignment:

- Select one of the organizational risks from the Vila Health: Patient Safety simulation. These included a patient identification error, a medication error, and a HIPAA/privacy violation. For part 2 of this assignment, you will conduct an in-depth analysis of the organizational risk you selected.
- Consult the readings listed in the assignment preparation study in Unit 3.
- Review the Assignment 2 template (provided in the resources), which you will use to complete your assignment. This document is formatted and has space for completing all components of the assignment.

Instructions

Part 1: Risk Management Policy and Procedure (3–4 pages)

As the new risk manager in your health care organization, your director has assigned you responsibility for drafting the organization's risk management policy and procedure. This assignment stemmed from your director's perception that employees lacked knowledge and awareness of risk management's contribution to furthering the organization's safety and quality improvement efforts. Likewise, your director also saw evidence that departments within the organization were inconsistently applying risk management principles to their daily work practices.

The guidance you have received from your director about writing this policy and procedure is that it needs to include all of the following headings. It also needs to answer all of the questions underneath each heading:

- Purpose Statement:
  - How can a risk management program help this organization advance its strategic safety and quality goals?
- Key Risk Management Terms:
  - What is the definition for each of these risk management terms?
    - Risk prevention.
    - Risk reduction.
    - Regulatory compliance.
    - Patient safety.
    - Adverse event.
    - Near miss.
- Risk Categories and Risk Identification Techniques:
  - What are the major risk categories in health care? In your answer, be sure to explain each risk category and to provide relevant examples from the literature to illustrate your points.
  - What risk management strategies will the organization use to identify potential organizational risks? Be sure your narrative identifies and describes such risk identification techniques as concurrent, retrospective, incident reporting, and previous trends. **Note**: These are only a few of the risk identification techniques to address in your policy and procedure. Be sure to include other examples you are aware of from your professional experience or from your readings.
  - What are examples of risk categories and their appropriate corresponding risk identification techniques? For example, coding errors are a type of financial risk. Retrospective auditing is the risk identification technique used to identify this risk type.
- Risk Manager's Role in Program Implementation and Compliance:
  - What is the risk manager's role in risk management program implementation and compliance?
  - How can a risk manager impact effective management of the organization's risk management program?
  - What is one example from the literature that shows how the risk manager role can positively impact a health care organization's management of its risk management program?

Part 2: Application of Risk Management Principles to a Specific Incident (3–4 pages)

To further help employees and the organization at large see risk management's contribution to helping the organization achieve its safety and quality goals, your director has asked you to analyze and apply risk management principles to a recent incident that occurred in the organization. Your director has asked you to include all of the following headings in your analysis and to address all of the questions underneath each heading.

- Risk Description:
  - Which potential risk to your organization from the Vila Health: Patient Safety simulation are you analyzing? These included a patient identification error, a medication error, and a HIPAA/privacy violation.
- Risk Implications:

    - What are the risks to the patients, employees, and organization if this particular risk is not addressed? In other words, what could happen if the organization chooses to do nothing?
- Risk Identification:
    - What risk management strategies and techniques will the organization employ to identify this type of risk in the future? For example, will the organization identify this type of risk by analyzing incident report data? What other strategies might the organization employ to identify the risk? Be sure to include your rationale for choosing the particular strategies.
- Risk Reduction/Elimination:
    - What risk management best practices could the organization employ to eliminate or reduce the risk in the future? For example, if you plan to identify the risk by analyzing incident report data, would you conduct a drill down to determine what is causing the risk? What other best practices might you employ? Consult your suggested resources for guidance on best practices for eliminating and reducing risk.
    - What steps would you take to implement your plan to eliminate or reduce your selected risk?
- Importance of a Risk Management Program:
    - Provide a comprehensive explanation of the importance of a risk management program to health care organizations.

Please review the Risk Management Policy and Procedure Scoring Guide to ensure you understand the grading requirements for this assignment.

Additional Requirements

Your assignment should also meet the following requirements:

- **Template**: Use the Assignment 2 template (provided in the resources) to complete this assignment.
- **Length**: 6–8 double-spaced pages, not including title and reference pages.
- **Font and font size**: Times New Roman, 12 point.
- **APA format**: Your submission, including the body, citations, and title and references pages need to conform to current APA format and style guidelines. Do make sure that it is clear, persuasive, organized, and well written, without grammatical, punctuation, or spelling errors. You also must cite your sources according to current APA guidelines.

References

Hoarle, K. (2015). Risk management poised to grow as healthcare evolves. *Biomedical Instrumentation & Technology*, *49*(6), 433–435.

Pelletier, L. R., & Beaudin, C. L. (2018). *HQ solutions: Resource for the healthcare quality professional* (4th ed.). Philadelphia, PA: Wolters Kluwer.

Course Resources

APA Module
APA Style and Format
Health Care Administration Undergraduate Library Research Guide
APA Style Paper Tutorial [DOCX]
Assignment 2 Template [DOC]
Vila Health: Patient Safety | Transcript

u04d1 - Strategies to Control Risk

For this discussion, you will evaluate the incident reporting process as an organizational strategy to control risk from a system perspective.

In your post:

- Describe the incident reporting process.
    - How is it used?
    - Who completes it?
    - What information does it contain?

- Evaluate how valuable it is to the risk management program. Why? Support your rationale with at least one reference from the literature.

Cite your sources as appropriate in current APA style.

Response Guidelines

As noted in the FEM, provide substantive comments to your peers, comparing his or her perspective to yours. Ask any questions that will help you better understand your peer's perspective.

Course Resources
Undergraduate Discussion Participation Scoring Guide
APA Module
Health Care Administration Undergraduate Library Research Guide

u04d1 - Learning Components

- Evaluate the incident reporting process and its importance to a risk management program.

Unit 5 >> Quality Improvement

Introduction

Depending upon the organization, continuous quality improvement (CQI) programs will differ in size and scope and may be referred to by a variety of different terms, such as quality and performance improvement, quality management, regulatory compliance, and quality improvement (Sollecito & Johnson, 2013). "It is an example of the evolutionary process that started [primarily] with industrial applications . . . and has now spread throughout the world, affecting many economic sectors, including health care" (Sollecito & Johnson, 2013, p. 3). Despite the progress in CQI, the need for greater efforts in health care quality improvement continues due to the vibrant and complex health care environment.

CQI is a "structured organizational process for involving personnel in planning and executing a continuous flow of improvements to provide quality health care that meets or exceeds expectations" (Sollecito & Johnson, 2013, p. 4). Realizing that quality is a vital component of the strategic plan, health care organizations have increased their focus on quality improvement efforts (White, 2012).

A common set of features characterizes CQI, which includes the following (Sollecito & Johnson, 2013, pp. 4–5):

- A link to key elements of the organization's strategic plan.
- A quality council made up of the institution's top leadership.
- Training programs for personnel.
- Mechanisms for selecting improvement opportunities.
- Formation of process improvement teams.
- Staff support for process analysis and redesign.
- Personnel policies that motivate and support staff participation in process improvement.
- Application of the most current and rigorous techniques of the scientific method and statistical process control.

References

Sollecito, W. A., & Johnson, J. K. (2013). *Mclaughlin and Kaluzny's continuous quality improvement in health care* (4th ed.). Burlington, MA: Jones & Bartlett Learning.

White, S. V. (2012). *Essential resources for the healthcare quality professional: Quality and performance improvement* (3rd ed.). Glenview, IL: National Association of Healthcare Quality.

Learning Activities

u05s1 - Studies

Readings

Use the Capella library to read the following:

- Barlow, R. D. (2015). Silver Cross spins gold lining into sterile processing operations progress: Tarnish turned to tinsel from team-based performance improvement. *Healthcare Purchasing News*, *39*(5), 10–14.
- Chassin, M. R., & Loeb, J. M. (2013). High-reliability health care: Getting there from here. *Milbank Quarterly*, *91*(3), 459–490.
- Ewen, B. M., Combs, R., Popelas, C., & Faraone, G. M. (2012). Chemotherapy in home care: One team's performance improvement journey toward reducing medication errors [PDF]. *Home Healthcare Now*, *30*(1), 28–37.
- Mannon, M. (2014). Lean healthcare and quality management: The experience of ThedaCare. *The Quality Management Journal*, *21*(1), 7–10.
- Masternak, R. L. (2012). Engaging staff with team-based performance sharing. *Healthcare Financial Management*, *66*(5), 120–124.

Use the Internet to read the following:

- U.S. Department of Health and Human Services, Health Resources and Services Administration. (n.d.). *Improvement teams* [PDF]. Retrieved from https://www.hrsa.gov/sites/default/files/quality/toolbox/508pdfs/improvementteams.pdf
- ASQ. (n.d.). About teams. Retrieved from https://asq.org/quality-resources/teams

Multimedia

Complete the following Capella multimedia presentations to learn more about quality improvement models:

- Models for Assessing Quality Improvement Efforts.
  - This media will help you learn about differences between quality assurance (QA) and total quality management (TQM) and CQI.
- Models of Quality Improvement.
  - This media provides a comparison of various models for quality improvement programs.

Optional Readings

You may choose to read the following optional materials to further your understanding of the topics in this unit:

- Institute for Healthcare Improvement. (n.d.). Plan-Do-Study-Act (PDSA) worksheet. Retrieved from http://www.ihi.org/resources/Pages/Tools/PlanDoStudyActWorksheet.aspx
  - To access this resource, you will need to set up a free account with IHI.

u05s2 - Assignment Preparation

In Unit 7, you will submit your third assignment, which focuses on collaboration. If you have not already started working on the assignment, begin now by researching the relevant topics. Review the Collaborating on Quality: Issue Analysis and Leadership Action Plan assignment description and scoring guide to learn more about the assignment expectations.

u05d1 - The Quality Improvement Team

Improvement in health care organizations is commonly coordinated through quality improvement teams made up of diverse professional backgrounds. The success of the improvement initiatives is dependent upon the quality of the team and their ability to work together as well as with others in the organization.

In your post:

- Define the role of the quality improvement team.
- Identify a quality improvement initiative and offer suggestions as to which members of the organization would be selected to be on the team.
- Offer rationale as to why you selected each member.

Cite your sources using current APA style.

Response Guidelines

As noted in the FEM, provide substantive comments to your peers, comparing his or her perspective to yours. Ask any questions that will help you better understand your peer's perspective.

Course Resources
Undergraduate Discussion Participation Scoring Guide
APA Module
Health Care Administration Undergraduate Library Research Guide

u05d1 - Learning Components

- Define the role and makeup of a quality improvement team.

u05d2 - Benchmarking

Benchmarking is used by organizations to compare their processes and successes to those of their competitors or other top-performing organizations. In doing so, an organization can identify variations in its process and highlight opportunities for improvement.

In your post, analyze the function of benchmarking as follows:

- Describe the benefits for the organization.
- Describe the benefits for consumers.
- Explain how benchmarks are determined.
- Explain how benchmarks may substantiate the need for improvement within the organization.
- Identify one health care benchmark and the source from which you obtained it.

Cite your sources using current APA style.

Response Guidelines

As noted in the FEM, provide substantive comments to your peers, comparing his or her perspective to yours. Ask any questions that will help you better understand your peer's perspective.

Course Resources
Undergraduate Discussion Participation Scoring Guide
APA Module
Health Care Administration Undergraduate Library Research Guide

u05d2 - Learning Components

- Analyze the benefits of benchmarking for process improvement efforts in an organization.

Unit 6 >> Tools and Resources in Quality Improvement

Introduction

"As CQI philosophies and processes have evolved within health care, a series of broad-based approaches have evolved and proven to be successful across a range of health care settings" (Sollecito & Johnson, 2013, p. 36). In 1988, the U.S. Office of Technology Assessment (OTA) defined quality of care as "the degree to which the process of care increases the probability of outcomes desired by the patient, and reduces the probability of undesired outcomes, given the state of medical knowledge" (OTA, 1988). To measure the degree to which outcomes are improved, organizational measures are

identified and selected. All evaluations of quality in health care can be classified into one of four categories: structural, process, outcome, and balancing measures (White, 2012).

Focusing on high-risk, high-volume, problem-prone areas is suggested to maximize returns on organizational investment in performance improvement. These improvements generally focus on positively affecting a large group of patients, eliminating or reducing variability in process, reducing risk, and avoiding serious problems within the organization (White, 2012). Critical elements when selecting a performance measure include:

- Relevance – Does the measure relate to the organization's improvement goals?
- Reliability – Does the measure accurately and consistently measure what it was intended to?
- Validity – Does the measure identify opportunities for improvement?

In addition to measuring outcomes for improvement, various stakeholder groups (patients, hospitals, professional societies, regulatory agencies, et cetera) have begun to seek outcome data. Transparent data assists with decision making, developing treatment protocols, performance measurement, and effectiveness research to name a few.

Tied with outcome measures are CQI methods and tools used for decision making, measuring variation, and process improvement. Walter Shewhart was the first to introduce the plan-do-check-act cycle (later modified to plan-do-study-act, or PDSA) used for rapid change, which puts the improvement in the hands of those are most directly responsible for the outcomes and processes in need of improvement (front-line staff and managers). Lean and Six Sigma, two additional tools used by quality professionals, are focused on reducing waste and eliminating defects resulting in added value for the customer.

References

Sollecito, W. A., & Johnson, J. K. (2013). *Mclaughlin and Kaluzny's continuous quality improvement in health care* (4th ed.). Burlington, MA: Jones & Bartlett Learning.

U.S. Office of Technology Assessment. (1988). *The quality of medical care: Information for consumers*. Washington, DC: U.S. Government Printing Office.

White, S. V. (2012). *Essential resources for the healthcare quality professional: Quality and performance improvement* (3rd ed.). Glenview, IL: National Association of Healthcare Quality.

Learning Activities

u06s1 - Studies

Readings

Use the Capella library to read the following:

- Millar, R. (2013). Framing quality improvement tools and techniques in healthcare. *Journal of Health Organization and Management, 27*(2), 209–224.
- Reed, J. E., & Card, A. J. (2016). The problem with plan-do-study-act cycles. *BMJ Quality & Safety*, *25*(3),147–152.
- Weiner, J., Balijepally, V., Tanniru, M., & Bujnowski, A. M. (2015). Integrating strategic and operational decision making using data-driven dashboards: The case of St. Joseph Mercy Oakland Hospital. *Journal of Healthcare Management*, *60*(5), 319–331.

Use the Internet to read or view the following:

- Agency for Healthcare Research and Quality. (n.d.). Guidelines and measures. Retrieved from https://www.ahrq.gov/gam/index.html
- Agency for Healthcare Research and Quality. (n.d.). Plan-Do-Study-Act (PDSA) cycle. Retrieved from http://innovations.ahrq.gov/qualitytools/plan-do-study-act-pdsa-cycle
- NCQA. (n.d.). HEDIS and performance measurement. Retrieved from https://www.ncqa.org/hedis/
- HealthyPeople.gov. (n.d.). Leading health indicators. Retrieved from https://www.healthypeople.gov/2020/Leading-Health-Indicators
    - Read the topics presented on this page.
- Institute for Healthcare Improvement. (Producer). (n.d.) *PDSA cycles (part 1)* [Video]. Retrieved from http://www.ihi.org/education/IHIOpenSchool/resources/Pages/AudioandVideo/Whiteboard5.aspx
    - Link to transcript is provided on the page.

Optional Readings

You may choose to read the following optional materials to further your understanding of the topics in this unit:

- Kovach, J. V., Revere, L., & Black, K. (2013). Error proofing healthcare: An analysis of low cost, easy to implement and effective solutions. *Leadership in Health Services*, *26*(2), 107–117.

- Carroll, C., Flucke, N., Barton, A. J., & Thompson T. L. (2013). The use of dashboards to monitor quality of care. *Clinical Nurse Specialist*, *27*(2), 61–62.
- Fracasso, M. R., & Sanders, B. (2012). Two keys to deliver better care and measure quality: Pod implementation & dashboards. *Physician Executive*, *38*(6), 48–52, 54.
- Centers for Medicare & Medicaid Services. (n.d.). *PDSA cycle template* [PDF]. Retrieved from https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/PDSACycledebedits.pdf

u06s2 - Assignment Preparation

In Unit 7, you will submit your third assignment, which focuses on collaboration. If you have not already started working on the assignment, begin now by researching the relevant topics. Review the Collaborating on Quality: Issue Analysis and Leadership Action Plan assignment description and scoring guide to learn more about the assignment expectations. Also, take time to read or review the required and optional readings for completing this assignment.

Readings

Use your *Patient Safety Handbook* text to read the following:

- Chapter 6, "The Role of the Board of Directors in Advancing Patient Safety," pages 69–86.
- Chapter 16, "The Leadership Role of the Chief Operating officer in Aligning Strategy and Operations to Create Patient Safety," pages 201–216.

Read the following handout:

- Importance and Features of Continuous Quality Improvement (CQI) [PDF].

Use the Capella library to read or review the following:

- Berwick, D. M., Nolan, T. W., & Whittington, J. (2008). The Triple Aim: Care, health and cost. *Health Affairs*, *27*(3), 759–769.
- Berry, J. C., Davis, J. T., Bartman, T., Hafer, C. C., Lieb, L. M., Khan, N., & Brilli, R. J. (2016). Improved safety culture and teamwork climate are associated with decreases in patient harm and hospital mortality across a hospital system [PDF]. *Journal of Patient Safety*.
- Miranda, S., Jr., & Olexa, G. A. (2013). Creating a just culture. *Pennsylvania Nurse*, *68*(4), 4–10.
- Stevens, M. (2014). Just culture: A fairer way to improve care. *Healthcare Leadership Review*, *33*(7), 8–10.

Use the Internet to read, review, or view the following:

- Institute for Healthcare Improvement. (n.d.). IHI Triple Aim initiative. Retrieved from http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx
- U.S. Department of Health and Human Services, Health Resources and Services Administration. (n.d.). *Improvement teams* [PDF]. Retrieved from https://www.hrsa.gov/sites/default/files/quality/toolbox/508pdfs/improvementteams.pdf
- Institute for Healthcare Improvement. (Producer). (n.d.). *What is a culture of safety?* [Video]. Retrieved from http://www.ihi.org/education/IHIOpenSchool/resources/Pages/Activities/Bates-What-Is-A-Culture-Of-Safety.aspx
    - Link to transcript is provided on the page.

Optional Readings

The following resources will be helpful in completing the Unit 7 assignment.

Collaboration and Teamwork

You may read or review the following:

- ASQ. (n.d.). About teams. Retrieved from https://asq.org/quality-resources/teams
- National Association for Healthcare Quality. (2018). NAHQ code of ethics for healthcare quality professionals and code of conduct. Retrieved from https://nahq.org/about/code-of-ethics

Quality Improvement Tools

You may review the following:

- Kovach, J. V., Revere, L., & Black, K. (2013). Error proofing healthcare: An analysis of low cost, easy to implement and effective solutions. *Leadership in Health Services*, *26*(2), 107–117.

- Millar, R. (2013). Framing quality improvement tools and techniques in healthcare. *Journal of Health Organization and Management, 27*(2), 209–224.

Culture

You may read the following:

- Frank-Cooper, M. (2014). The justice behind a just culture. *Nephrology Nursing Journal*, *41*(1), 87–88.

u06d1 - The Function of Measurement in Quality Improvement

Measurement is a critical function in quality improvement. Health care organizations utilize measurement tools to track their performance in various dimensions, including clinical quality, patient safety, patient satisfaction, financial performance, et cetera. Once selected, the measurements are organized and reported out via scorecards and dashboards.

For this discussion, research the literature and identify one health care metric for one of the following (handwashing, hospital acquired infection, patient registration, et cetera), or pick one you are familiar with or interested in.

In your post, describe the following:

- Importance of the metric.
- How the metric is measured.
- The intended purpose of the metric selected (such as quality improvement, accreditation and public reporting).

Cite your sources using current APA style.

Response Guidelines

As noted in the FEM, provide substantive comments to your peers, comparing his or her perspective to yours. Ask any questions that will help you better understand your peer's perspective.

Course Resources
Undergraduate Discussion Participation Scoring Guide
APA Module
Health Care Administration Undergraduate Library Research Guide

u06d1 - Learning Components

- Explain the use of metrics in health care.

u06d2 - Quality Models

In addition to scorecards and dashboards, many organizations utilize additional improvement methods and processes for performance improvement.

In your post:

- Compare and contrast various quality models (such as PDSA, Six Sigma, fishbone diagrams, Lean, et cetera), describing how the models can help to increase the quality of patient care and outcomes.
- Choose a performance improvement initiative and provide an example of how you would use one of the models to address the issue (for example, using a fishbone diagram to identify all factors associated with a medication error).
- Indicate why the model is the best for the initiative you selected.

Cite sources as appropriate using APA style.

Response Guidelines

As noted in the FEM, provide substantive comments to your peers, comparing his or her perspective to yours. Ask any questions that will help you better understand your peer's perspective.

Course Resources
Undergraduate Discussion Participation Scoring Guide
APA Module
Health Care Administration Undergraduate Library Research Guide

u06d2 - Learning Components

- Explain how quality models can be applied to performance improvement plans.

Unit 7 >> Leadership

Introduction

"Being in a position of leadership is the most important job of any health professional anywhere along the continuum of care" (Ledlow & Coppola, 2013, p. 3). Leaders and ultimately the boards of directors of health care organizations are accountable for the safety of those they serve. "National quality organizations and regulatory bodies . . . are growing in their emphasis on leadership accountabilities for safe, reliable care as well as excellence in the experience of care" (Youngberg, 2013, p. 39).

"Leaders should commit at the organizational level to drive change and improvement in patient safety practices" (Beaudin & Pelletier, 2012, p. 10). Demonstration of this requires leaders to incorporate health care safety practices as a part of the organization's strategic direction, and to develop goals to guarantee adoption and measurement of safe practices. The governing body or board of directors is responsible for endorsing and upholding quality of care and preserving safety. Quality oversight is recognized more clearly as a core fiduciary duty relating not only to financial health and reputation but to safety and quality of care (Beaudin & Pelletier, 2012).

References

Beaudin, C. L., & Pelletier, L. R. (2012). *Essential resources for the healthcare quality professional: Healthcare safety* (3rd ed.). Glenview, IL: National Association of Healthcare Quality.

Ledlow, G. R., & Coppola, M. N. (2013). *Leadership for health professionals* (2nd ed.). Burlington, MA: Jones & Bartlett Learning.

Youngberg, B. J. (2013). *Patient safety handbook* (2nd ed.). Burlington, MA: Jones & Bartlett Learning.

Learning Activities

u07s1 - Studies

Readings

Use your *Patient Safety Handbook* text to read or review the following:

- Chapter 4, "The Importance of Leadership to Advance Patient Safety," pages 39–56.
- Chapter 6, "The Role of the Board of Directors in Advancing Patient Safety," pages 69–86.
- Chapter 16, "The Leadership Role of the Chief Operating officer in Aligning Strategy and Operations to Create Patient Safety," pages 201–216.

Use the Internet to read or review the following:

- Leape, L. L. (2011). A blueprint on patient safety. Retrieved from http://archive.boston.com/bostonglobe/editorial_opinion/blogs/the_podium/2011/11/_by_lucian_l_leape.html
- Centers for Disease Control and Prevention. (n.d.). National Healthcare Safety Network (NHSN). Retrieved from https://www.cdc.gov/nhsn/
- Institute for Healthcare Improvement. (Producer). (n.d.). *What is a culture of safety?* [Video]. Retrieved from http://www.ihi.org/education/IHIOpenSchool/resources/Pages/Activities/Bates-What-Is-A-Culture-Of-Safety.aspx
    - Link to transcript is provided on the page.

Multimedia

Complete the following Capella multimedia presentation:

- Knowledge Check: Continuous Quality Improvement and a Fair and Just Culture.
  - This media provides an opportunity to self-check your knowledge of the best practices that first-in-class health care organizations engage in to establish fair and just cultures that focus on CQI. This knowledge will serve you well as you analyze a specific incident that occurred in a health care organization and create a leadership action plan that helps to drive safety and CQI throughout the organization.

Optional Readings

You may choose to read the following optional materials to further your understanding of the topics in this unit:

- Reinertsen, J. L., Bisognano, M., & Pugh, M. D. (2008). *Seven leadership leverage points for organization-level improvement in health care* (2nd. ed). Cambridge, MA: Institute for Healthcare Improvement. Retrieved from http://www.ihi.org/resources/Pages/IHIWhitePapers/SevenLeadershipLeveragePointsWhitePaper.aspx
  - **Note**: You will need to register with IHI to view this material. The registration is free.

u07a1 - Collaborating on Quality: Issue Analysis and Leadership Action Plan

Introduction

In this third assignment in the course, you will assume the role of a newly promoted quality manager at your local hospital. This role requires you to address deficiencies by improving organizational culture, providing leadership oversight, and cultivating staff relationships within the organization. While you have many priorities in this new role, one of your first is to analyze a recent incident that occurred within the organization and to create a leadership action plan with recommended strategies and tactics to address not just the specific incident, but to drive safety and quality improvement throughout the organization.

This assignment differs from the first two assignments in that with this, as the quality manager, your focus is broader. Rather than focusing only on identifying specific actions the organization can take to remedy a particular incident that occurred, you are concentrating on what steps you will take as the quality manager to influence the organization's leadership to cultivate a fair and just culture. You will determine what departments, what leaders, and what personnel you will collaborate with to improve quality for the whole organization. In this type of culture, safety is at the forefront of everyone's job and all associates welcome the opportunity to highlight issues—without fear of reprisal—so that they can be addressed at a systemic level throughout the organization.

You may find it useful to review the short document Importance and Features of Continuous Quality Improvement (CQI) (given in the resources) as you gather your thoughts about the key elements you want to include in this assignment.

Demonstration of Proficiency

By successfully completing this assignment, you will demonstrate proficiency in the following course competencies. Refer to the scoring guide for further details.

- Competency 4: Apply leadership strategies to quality improvement in a health care organization.
- Competency 5: Communicate in a manner that is scholarly, professional, and respectful of the diversity, dignity, and integrity of others and is consistent with the expectations for health care professionals.

Summary

Prepare an issue analysis of an incident that occurred in a health care organization and create a leadership action plan (8–10 pages) that will help to address the specific incident but will also help to drive safety and quality improvements throughout the organization.

Preparation

To successfully complete this assignment:

- Select one of the three incidents from the Vila Health: Patient Safety simulation. These are common incidents you are likely to encounter in the health care field. These included a patient identification error, a medication error, and a HIPAA/privacy violation. You may select one of the incidents you worked with in the previous assignments or select another one. Choose one that holds the most interest for you.
- Consider the following analysis questions once you have selected the incident on which you will focus:

    - What information do you possess about the issue? (**Note**: You may not be able to answer all of these questions; just include the information you know.) Consider:
        - Who was involved?
        - During what process (clinical, communication, or operational) did the issue occur?
        - When did the issue occur? During a particular shift? On a particular day? During peak hours? Under certain clinical circumstances?
        - Where did the issue occur?
    - What additional data about the incident would you like to collect and analyze?
    - Which best practices may not have been adhered to that may have contributed to the issue? (**Note**: This information will prove useful to you as you complete your analysis and leadership action plan.)
- Consult the readings listed in the assignment preparation study in Unit 6.
- Review the Assignment 3 template (provided in the resources), which you will use to complete this assignment. This document is formatted and has space for completing all components of the assignment.

Instructions

Write an analysis and leadership action plan for the issue you selected that will enable you to address the issue on an organization-wide basis. Please make sure to include all of the following headings and answer all of the questions underneath each heading.

Introduction: Issue Summary

Address the following:

- How would you summarize the key elements of the incident that occurred?
- What is your goal in addressing the issue?
- Which 2–3 key items will be your focus? For example, you may elect to focus on nursing staffing levels if being short staffed in nursing is contributing to compromises to patient safety.

Culture

Address the following:

- What is culture?
- Why is culture a critical organizational priority for safety and quality?
- What do you know about the existing organizational culture, based on the knowledge you have about the selected issue?
- What are some of the evidence-based strategies you are considering that could be employed to cultivate a culture of safety?

IHI Triple Aim

Address the following:

- What is the IHI Triple AIM?
- How does the IHI Triple Aim apply to this specific incident?
- What IHI Triple Aim elements will you incorporate into your organizational improvement strategy?

Leadership and Collaboration

Address the following:

- Which key departments need to be directly involved with the corrective action process?
- What is your rationale for selecting these departments? For example, you may want to involve nursing because many of errors involve nurses and obtaining their buy-in is critical to achieving the organizational priority.
- Which specific senior leader, front-line staff member, and clinical expert will you include in your action plan and hold accountable for implementation?
- What are the implications of not engaging with *all d*epartments toward making safety and quality top of mind?
- How might you involve other departments in addressing the specific issue and the cultural issue?
- Which specific leaders within the organization could assist you in addressing this issue and in making patient safety and quality top of mind throughout the organization? Examples for you to consider include the chief nursing officer, the chief medical officer, the patient safety officer, et cetera.
- What role do you expect these leaders to play in addressing the specific issue and the issue of culture?
- What best practices would you employ to enlist their aid in the improvement effort?

Leadership Action Plan

Address the following:

- What are three evidence-based actions you recommend that would help to solve the incident that occurred?
- What are three evidence-based best practices you recommend to address the issue on an organizational level?

Opportunities to Enlist Governing Board

Address the following:

- What role does the organization's governing board have in terms of quality and safety in the organization?
- How could you enlist the governing board's aid in your improvement initiative?
- What additional information could you provide them to increase their involvement in the organization's safety and quality improvement efforts?

Conclusion

How will you summarize your analysis of the incident and your leadership action plan?

Remember that health care is an evidence-based field. You will need to cite a *minimum* of two credible references to support your analysis and action planning process.

In addition, your assignment needs to conform to current APA style and format guidelines. Do ensure that it is clear, persuasive, concise, organized, and without errors in grammar, punctuation, and spelling. Do provide citations and title and reference pages in current APA format. Other leaders in your organization are going to want to know what sources you relied on to prepare your analysis and action plan.

Please review the Collaborating on Quality: Issue Analysis and Leadership Action Plan Scoring Guide to ensure you understand the grading requirements for this assignment.

Additional Requirements

Your assignment should also meet the following requirements:

- **Template**: Use the Assignment 3 template (provided in the resources) to complete this assignment.
- **Length**: 8–10 double-spaced pages, not including title and reference pages.
- **Font and font size**: Times New Roman, 12 point.
- **APA format**: Your submission, including the body, citations, and title and reference pages need to be in APA format and style guidelines. It does need to be well written, include the headings specified in the instructions, and address the questions listed under each heading.

Course Resources
APA Module
APA Style and Format
APA Style Paper Tutorial [DOCX]
Health Care Administration Undergraduate Library Research Guide
Assignment 3 Template [DOC]
Importance and Features of Continuous Quality Improvement (CQI) [PDF]
Vila Health: Patient Safety | Transcript

u07d1 - Role of the Governing Board

Leadership is essential to quality, patient safety, risk management, and performance improvement. Organizational leadership focuses on many things including setting direction, established foundations, and leading through change.

In your post, explain the role of the governing board as it relates to oversight of the quality and performance improvement (QPI) activities.

- What is the involvement of the governing board in establishing priorities for QPI within the organization?
- When should the board be involved in or informed of poor outcomes or compromised patient care?

- How would you evaluate the importance of involving the governing board in the early development of quality measures?

Cite your sources using current APA style.

Response Guidelines

As noted in the FEM, provide substantive comments to your peers, comparing their perspective to yours. Ask any questions that will help you better understand your peer's perspective.

Course Resources
Undergraduate Discussion Participation Scoring Guide
APA Module
Health Care Administration Undergraduate Library Research Guide

u07d1 - Learning Components

- Evaluate the role of the governing board in relationship to oversight of quality and performance improvement activities.
- Explain the role of the governing body as it relates to leadership strategy and commitment to patient safety and health care quality.

Unit 8 >> Monitoring for Quality

Introduction

Once the health care organization has selected the indicators it would like to measure (such as proper hand washing, hospital-acquired infection rates, and readmissions), data are then collected to measure the indicator and compare the organization's current performance to the desired performance level. Potential sources for data within the organization are extensive, and some are simple to access while others pose significant challenges. Sources for data at the average hospital include, but are not limited to, the medical record, surveys, prospective data collection, focus groups, administrative databases, patient registries, health plan claims, and cost accounting systems. To identify the appropriate data set needed to measure the selected indicator or performance improvement initiative, the following items are important to consider (Joshi, Ransom, Nash, & Ransom, 2014):

- Are the data accessible?
- Are the data accurate?
- Are the data reliable?
- Are the data timely?
- Does the data allow for measurement of the identified metric?

Reference

Joshi, M. S., Ransom, E. R., Nash, D. B., & Ransom, S. B. (2014). *The healthcare quality book: Vision, strategy, and tools* (3rd ed.). Chicago, IL: Health Administration Press.

Learning Activities

u08s1 - Studies

Readings

Use the Capella library to read the following:

- Sarkies, M. N., Bowles, K. A., Skinner, E. H., Mitchell, D., Haas, R., Ho, M., . . . Haines, T. P. (2015). Data collection methods in health services research: Hospital length of stay and discharge destination. *Applied Clinical Informatics*, *6*(1), 96–109.

Use the Internet to read or review the following:

- Agency for Healthcare Research and Quality. (2018). Race, ethnicity, and language data: Standardization for health care quality improvement. Retrieved from https://www.ahrq.gov/research/findings/final-reports/iomracereport/reldata5.html

- Angier, H., Gold, R., Gallia, C., Casciato, A., Tillotson, C. J., Marino, M., . . . DeVoe, J. E. (2014). Variation in outcomes of quality measurement by data source. *Pediatrics*, *133*(6), 1676–1682. Retrieved from http://pediatrics.aappublications.org/content/133/6/e1676
- Joint Commission. (2018). Facts about ORYX for hospitals (national hospital quality measures). Retrieved from https://www.jointcommission.org/facts_about_oryx_for_hospitals/
- U.S. Department of Health and Human Services, Health Resources and Services Administration. (n.d.). *Improvement teams* [PDF]. Retrieved from https://www.hrsa.gov/sites/default/files/quality/toolbox/508pdfs/improvementteams.pdf

Optional Readings

You may choose to read the following optional materials to further your understanding of the topics in this unit:

- Abel, E. A., Brandt, C. A., Czlapinski, R., & Goulet, J. L. (2016). Pain research using Veterans Health Administration electronic and administrative data sources. *Journal of Rehabilitation Research and Development*, *53*(1), 1–11.
- Kilpeläinen, K., Parikka, S., Koponen, P., Koskinen, S., Rotko, T., Koskela, T., & Gissler, M. (2016). Finnish experiences of health monitoring: Local, regional, and national data sources for policy evaluation. *Global Health Action*, *9*.

u08s2 - Assignment Preparation

In Unit 9, you will submit your final assignment, in which you will create a PowerPoint presentation focused on quality dashboards. If you have not already started working on the assignment, begin now by researching the relevant topics. Review the Analyzing and Applying Dashboard Data assignment description and scoring guide to learn more about the assignment expectations. Also, take time to read or review the required and optional readings for completing this assignment.

Consult the following library guide for additional guidance on how to conduct research on quality improvement tools and other topics that will help you successfully complete your assignment.

- Health Care Administration Undergraduate Library Research Guide.

Readings

Use the Capella library to read or review the following:

- Carroll, C., Flucke, N., Barton, A. J., & Thompson T. L. (2013). The use of dashboards to monitor quality of care [PDF]. *Clinical Nurse Specialist*, *27*(2), 61–62.
- Hall, J. T., & Kelly, C. M. (2014). A partnership to enhance outcomes through quality dashboards and action planning. *American Nurse Today, 9*(1), 58–61.
- Mannon, M. (2014). Lean healthcare and quality management: The experience of ThedaCare. *The Quality Management Journal*, *21*(1), 7–10.

Read the following handouts:

- Measurement Perspectives [PDF].
- Vila Health Mercy Hospital Safety and Quality Dashboard [PDF].

Use the Internet to review the following:

- Agency for Healthcare Research and Quality. (n.d.). Guidelines and measures. Retrieved from https://www.ahrq.gov/gam/index.html
- NCQA. (n.d.). HEDIS and performance measurement. Retrieved from https://www.ncqa.org/hedis/

Optional Readings

The following resources will be helpful in preparation for the Unit 9 assignment. Choose those that are most appropriate for your work.

Quality Improvement Tools

You may review the following:

- Millar, R. (2013). Framing quality improvement tools and techniques in healthcare. *Journal of Health Organization and Management, 27*(2), 209–224.

Dashboards

You may review the following:

- Weiner, J., Balijepally, V., Tanniru, M., & Bujnowski, A. M. (2015). Integrating strategic and operational decision making using data-driven dashboards: The case of St. Joseph Mercy Oakland Hospital. *Journal of Healthcare Management*, *60*(5), 319–331.

Metrics

You may review the following:

- HealthyPeople.gov. (n.d.). Leading health indicators. Retrieved from https://www.healthypeople.gov/2020/Leading-Health-Indicators
    - Explore the 2020 LHI Topics on the far left side of the web page.

u08d1 - Technology and Patient Safety

Complexity and change are constant in the health care industry. Many of the errors common in health care are being eliminated through the implementation and use of technology.

In your post:

- Analyze how technology can be used to enhance a health care safety program.
- Provide an example of a common health care error and how technology has been implemented in an effort to reduce or eliminate future errors of the same type.

Cite your sources using current APA style.

Response Guidelines

As noted in the FEM, provide substantive comments to your peers, comparing their perspective to yours. Ask any questions that will help you better understand your peer's perspective.

Course Resources
Undergraduate Discussion Participation Scoring Guide
APA Module
Health Care Administration Undergraduate Library Research Guide

u08d1 - Learning Components

- Analyze how technology can be used to enhance a health care safety program.

u08d2 - Quality Data

Data are the foundation of quality improvement. Having access to timely data is important for quality leaders to identify various items, including, but not limited to, monitoring, identifying what is working toward improvement initiatives, allowing for comparison, and offering suggestions for areas that require improvement.

In your post, analyze the advantages and disadvantages of using medical records versus administrative sources for collecting quality data.

Cite your sources using current APA style.

Response Guidelines

As noted in the FEM, provide substantive comments to your peers, comparing their perspective to yours. Ask questions to better understand their perspective and expand the discussion.

Course Resources
Undergraduate Discussion Participation Scoring Guide
APA Module
Health Care Administration Undergraduate Library Research Guide

u08d2 - Learning Components

- Compare and contrast the advantages and disadvantages of data sources.
- Explain the role of data in quality improvement.

Unit 9 >> Culture

Introduction

Culture is "the set of shared attitudes, values, goals and practices that characterizes an institution or corporation" (Duquette, 2012, p. 51). All stakeholders are responsible for health care quality and safety within the organization, and these elements should be core components of the comprehensive health care safety program.

Leaders who wish to create a culture of safety must first assess their organization's readiness to implement the necessary safety practices. The Hospital Survey on Patient Safety Culture was developed in 2004 by the AHRQ as a tool to assess an organization's readiness and to evaluate the extent to which an organizational culture of safety already exists (Beaudin & Pelletier, 2012). In addition, the AHRQ has created culture assessment tools that allow organizations to identify benchmarks to establish a culture of safety in comparison to similar hospitals or hospital units. The fair and just culture encourages leaders to ask *what happened* instead of *who made the error* (Beaudin & Pelletier, 2012). Additionally, the fair and just culture aids in making the system safer, as stakeholders understand errors are inevitable and that all errors should be reported, even when events may not cause patient harm (Beaudin & Pelletier, 2012).

References

Duquette, C. E. (2012). *Essential resources for the healthcare quality professional: Leadership and management* (3rd ed.). Glenview, IL: National Association of Healthcare Quality.

Beaudin, C. L., & Pelletier, L. R. (2012). *Essential resources for the healthcare quality professional: Healthcare safety* (3rd ed.). Glenview, IL: National Association of Healthcare Quality.

Learning Activities

u09s1 - Studies

Readings

Use your *Patient Safety Handbook* text to read the following:

- Chapter 5, "An Organization Development Framework for Transformation Change in Patient Safety: A Guide for Hospital Senior Leaders," pages 57–68.
- Chapter 13, "Creating a Just Culture: A Nonpunitive Approach to Medical Errors," pages 169–178.
- Chapter 31, "Supporting a Culture of Safety: The Magnet Recognition Program," pages 393–424.

Use the Capella library to review the following:

- Miranda, S., Jr., & Olexa, G. A. (2013). Creating a just culture. *Pennsylvania Nurse*, *68*(4), 4–10.
- Stevens, M. (2014). Just culture: A fairer way to improve care. *Healthcare Leadership Review*, *33*(7), 8–10.

Multimedia

Complete the following Capella multimedia presentation:

- Dashboard Analysis.
  - In this exercise, you will have the chance to practice and assess your dashboard analysis skills. You will examine the data contained in several different types of dashboards (clinical, financial, and operational) commonly found in health care. You will then glean critical information from these dashboards and practice interpreting what the data mean to safety and quality. You will also assess how effectively you are able to determine which organizational leaders are most accountable for certain dashboard indicators. This practice will help prepare you to successfully complete your assignment, which requires you to analyze a health care organization's quality and safety dashboard from the perspective of four different organizational leaders.

Optional Readings

You may choose to read the following optional materials to further your understanding of the topics in this unit:

- Chapter 38, "Moving Beyond Blame to Create an Environment That Rewards Reporting," pages 545–550, from your *Patient Safety Handbook* text.
- Berry, J. C., Davis, J. T., Bartman, T., Hafer, C. C., Lieb, L. M., Khan, N., & Brilli, R. J. (2016). Improved safety culture and teamwork climate are associated with decreases in patient harm and hospital mortality across a hospital system. *Journal of Patient Safety*.
- Frank-Cooper, M. (2014). The justice behind a just culture. *Nephrology Nursing Journal*, *41*(1), 87–88.
- Institute for Healthcare Improvement. (Producer). (n.d.). *What is a culture of safety?* [Video]. Retrieved from http://www.ihi.org/education/IHIOpenSchool/resources/Pages/Activities/Bates-What-Is-A-Culture-Of-Safety.aspx
  - Link to transcript is provided on the page.

u09a1 - Analyzing and Applying Dashboard Data

Introduction

"Being in a position of leadership is the most important job of any health professional anywhere along the continuum of care" (Ledlow & Coppola, 2013, p. 3). Leaders and ultimately the boards of directors of health care organizations are accountable for the safety of those they serve." National quality organizations and regulatory bodies . . . are growing in their emphasis on leadership accountabilities for safe, reliable care as well as excellence in the experience of care" (Youngberg, 2013, p. 39).

With this emphasis on leadership accountability for the delivery of safe, high-quality health care services, health care leaders need to be able to drill down on what exactly safety and quality mean in the health care environment. Likewise, they also need to be able to design measures that help to ensure their organizations are able to deliver those kinds of outcomes. Read the short document Measurement Perspectives (given in the resources) to examine key elements related to this issue.

In this final course assignment, you will have a unique opportunity to examine a health care organization's safety and quality dashboard from the perspective of four organizational leaders. You will explore each leader's specific interests regarding patient safety and quality. In particular, you will have the opportunity to perform a more in-depth analysis of the dashboard, the type of analysis a quality director might perform to further the organization's safety and quality objectives.

Demonstration of Proficiency

By successfully completing this assignment, you will demonstrate proficiency in the following course competencies. Refer to the scoring guide for further details.

- Competency 1: Analyze the quality and performance improvement activities within the health care organization.
- Competency 2: Explain the risk management function in the health care organization.
- Competency 3: Analyze the importance of patient safety in health care.
- Competency 4: Apply leadership strategies to quality improvement in a health care organization.
- Competency 5: Communicate in a manner that is scholarly, professional, and respectful of the diversity, dignity, and integrity of others and is consistent with the expectations for health care professionals.

Summary

Create a presentation (a maximum of 20 slides with detailed speaker notes) for senior leadership in which four organizational leaders analyze the impact of a health care organization's new safety and quality dashboard. Include an analysis of what the new metrics mean and how they will inform departmental activities for the next quarter.

Preparation

To successfully complete this assignment:

- Review the Assignment 4 Template (given in the resources). You will use this as a starting point or guide as you develop your presentation.
- Consult the readings listed in the assignment preparation study in Unit 8.

Instructions

Your organization has just updated its safety and quality dashboard. Please review the Vila Health Mercy Hospital Safety and Quality Dashboard (given in the resources). **Note**: You do not need to create a dashboard for this assignment. You are simply being asked to work with the one provided.

The CEO has asked each of the organizational leaders below to prepare a joint PowerPoint presentation. In the presentation, they are to prepare a set of slides outlining their analysis of how the new numbers will inform their particular activities for the next quarter. The organizational leaders include:

- The quality director.
- The patient safety officer.
- The risk manager.
- Senior leadership.

Because of the quality director's critical role in implementing the organization's safety and quality strategic objectives, this individual will open the presentation and provide additional background about how the new dashboard was developed. This individual will also close the presentation. Use the following outline to organize your presentation. Be sure to include the introduction and conclusion and address all the questions listed under these headings. Also be sure to address each role and the corresponding questions.

Introduction (1–2 slides)

Address the following:

- What is a safety and quality dashboard?
- What role do safety and quality dashboards play in helping health care organizations drive their strategic safety and quality objectives?

Evidence-Based Actions to Improve (2–3 slides)

Address the following:

- What measure on the health care organization's safety and quality dashboard was selected?
- What evidence-based actions to improve the selected measure are being recommended?

Metrics Selection (3–4 slides)

Address the following:

- How do health care organizations determine what they want to measure? Be sure to consider:
  - Pressures from regulators, payors, and the industry.
  - Self-identified improvement areas. For example, one organization's safety and quality dashboard may highlight patient falls because its rate of falls is higher than the national average. This may also have resulted in increased costs to the organization.
- What CQI tools did the organization use to obtain, measure, and report data?
- What was the quality improvement team’s role in addressing the reported measures?

Quality Director (2–3 slides)

Address the following:

- Which metric on the dashboard would draw the quality director's attention the most?
- What does this dashboard metric mean and why is it important?
- What three recommendations to leadership would help to address this metric?
- What (if any) quality models could be used to increase the quality of patient care and outcomes for this metric? Consider PDCA, Six Sigma, Lean, Hoshin Kanri planning, et cetera.

Patient Safety Officer (2–3 slides)

Address the following:

- Which metric on the dashboard would draw the patient safety officer's attention the most?
- What does this dashboard metric mean and why is it important?
- What role does the patient safety officer play in improving this metric?

Risk Manager (2–3 slides)

- Which metric on the dashboard would draw the risk manager's attention the most?
- What does this dashboard metric mean and why is it important?
- What role does the risk manager play in improving this metric?

Senior Leadership (1 slide)

Address the following:

- What is the role of senior leadership (for example, CEO, COO, president, or senior VP) in driving safety and quality improvement initiatives?
- What next steps might senior leadership take, given the dashboard findings and the quality director's three improvement recommendations?

Conclusion (2–3 slides)

Address the following:

- Which regulatory agencies may be concerned about the findings in this dashboard?
- Why would regulators be concerned about these findings?
- Why are safety and quality dashboards important for monitoring key metrics in health care organizations?

Your slides need to be concise and offer main ideas in bulleted format. Use the speaker notes to expand upon your findings as if they were the transcript of your presentation for the leadership team.

In the health care environment, it is unlikely for a presentation and speaker notes to be in APA style. Do make sure your presentation is concise, organized, clear, and free of errors in grammar, punctuation, and spelling. Do make sure the presentation addresses all the required headings and all of the questions under each heading.

Your senior leaders will want to know the sources of your information. Be sure to cite your sources in APA style in your speaker notes.

Please review the Analyzing and Applying Dashboard Data Scoring Guide to ensure you understand the grading requirements for this assignment.

Additional Requirements

Your assignment should also meet the following requirements:

- **Template**: Use the Assignment 4 template (provided in the resources) to complete this assignment.
- **Length**: A maximum of 20 slides, including title and reference slides. Format your title and reference slides according to current APA format.
- **Speaker notes**: Be sure to include these with your slides. They provide an opportunity for you to expand on the information you are highlighting in your slides.
- **Number of references**: A minimum of two references.

References

Ledlow, G. R., & Coppola, M. N. (2013). *Leadership for health professionals* (2nd ed.). Burlington, MA: Jones & Bartlett Learning.

Youngberg, B. J. (2013). *Patient safety handbook* (2nd ed.). Burlington, MA: Jones & Bartlett Learning.

Course Resources
APA Module
APA Style and Format
Health Care Administration Undergraduate Library Research Guide
Assignment 4 Template [PPTX]
Measurement Perspectives [PDF]
Vila Health: Mercy Hospital Safety and Quality Dashboard

u09d1 - Fair and Just Culture

Many of the errors in health care are linked to system or process failures. In other situations, errors will arise that are linked to recklessness, carelessness, human error, and blatant disregard for policy and process.

In your post:

- Describe the concept of fair and just culture.
- Identify one error that occurs as a result of an individual's motives or behaviors.
- Determine what steps should be taken to address the findings within a just culture.

Cite your sources using current APA style.

Response Guidelines

As noted in the FEM, provide substantive comments to your peers, comparing his or her perspective to yours. Ask any questions that will help you better understand your peer's perspective.

Course Resources
Undergraduate Discussion Participation Scoring Guide
APA Module
Health Care Administration Undergraduate Library Research Guide

u09d1 - Learning Components

- Analyze the concepts of fair and just culture.
- Analyze the importance of organizational culture to patient safety.

Unit 10 >> Operational Considerations for Safety and Quality

Introduction

Patient safety "requires an environment in which patients, their families, and organization staff and leaders can identify and manage actual and potential risks to safety" (Beaudin & Pelletier, 2012, p. 17). Operational considerations include health care information technology, risk management, safe medication practices, consumer empowerment, and safety practices. To solidify a health care organization's commitment to safety and quality, a written plan integrating patient safety and quality goals into organizational activities is advised (Beaudin & Pelletier, 2012).

Considerations should be given to the following (Beaudin & Pelletier, 2012, p. 18):

- Planning and designing services.
- Directing services.
- Integrating and coordinating services.
- Reducing and preventing errors.
- Following clinical practice guidelines.
- Activity involving patients and families in care.

In this unit, you will explore how many of the individual components you studied in the previous units will combine within the organization. You will wrap up our discussions, giving attention to their importance and function within the health care organization.

Reference

Beaudin, C. L., & Pelletier, L. R. (2012). *Essential resources for the healthcare quality professional: Healthcare safety* (3rd ed.). Glenview, IL: National Association of Healthcare Quality.

Learning Activities

u10s1 - Studies

Readings

Use your *Patient Safety Handbook* text to read or review the following:

- Chapter 11, "Patient Safety is an Organizational Systems Issue: Lessons From a Variety of Industries," pages 143–156.
- Chapter 22, "Teamwork: The Fundamental Building Block of High-Reliability Organizations and Patient Safety," pages 265–290.
- Chapter 7, "Toward a Philosophy of Patient Safety: Expanding the Systems Approach to Medical Error," pages 87–97.

Use the Internet to read the following:

- Agency for Healthcare Research and Quality. (2017). TalkingQuality. Retrieved from https://www.ahrq.gov/cpi/about/otherwebsites/talkingquality.ahrq.gov/index.html
- Centers for Medicare & Medicaid Services. (n.d.). Partnership for Patients. Retrieved from https://partnershipforpatients.cms.gov/

Multimedia

Complete the following Capella multimedia presentation:

- Patient-Centered Rules to Improve Quality of Care.

u10d1 - Operationalizing Preventing Harm

Preventing harm requires health care organizations to deliberately design organizational programs focused on patient safety.

In your post:

- Identify and describe two operational considerations for patient safety (for example, in the areas of safety development programs, information technology, risk management, safe medication practices, et cetera).
- Analyze the benefits and challenges of implementing each of the operational considerations you identified.
- Identify the opportunity cost of not implementing the operational consideration.

Cite your sources using current APA style.

Response Guidelines

As noted in the FEM, provide substantive comments to your peers, comparing their perspective to yours. Ask any questions that will help you better understand your peer's perspective.

Course Resources
Undergraduate Discussion Participation Scoring Guide
APA Module
Health Care Administration Undergraduate Library Research Guide

u10d1 - Learning Components

- Analyze operational considerations for patient safety.
- Analyze the importance of organizational culture in regard to patient safety.

u10d2 - Strategic Planning

Strategic planning requires the organization to document a plan for what the future of the organization will look like and how they plan on getting there. The foundation for the strategy is rooted in the organization's vision, mission, and values, with quality at its core. Organizational leadership identifies metrics, allowing them to identify when they have achieved their desired state.

In your post:

- Analyze the importance of including various stakeholders in the strategic planning process (such as physicians, nurses, front-line staff, finance, governing board, and patients).
- Evaluate the significance of empowering employees toward the development of a culture of quality within the organization.

Cite your sources using APA style.

Response Guidelines

As noted in the FEM, provide substantive comments to your peers, comparing their perspective to yours. Ask any questions that will help you better understand your peer's perspective.

Course Resources
Undergraduate Discussion Participation Scoring Guide
APA Module
Health Care Administration Undergraduate Library Research Guide

u10d2 - Learning Components

- Analyze the significance of stakeholder representation in the strategic planning process.