Safety Performance Improvement Assignment

NURS 490 - Nursing Leadership

Purpose of Assignment

To identify a safety issue within a health care organization that needs to change in order to promote better delivery of patient care; to demonstrate an ability to collaboratively problem-solve in an interdisciplinary environment while working towards resolution of a common problem.

Student Approach to Assignment

This assignment was a group project where we identified as a group various safety issues within healthcare delivery systems. The safety issue of choice that this group decided on was medication errors. By completing this assignment, we were able to research a common safety issue in the environment that we work in and attempt to make it better by identifying a plan for change.

Reason for Inclusion of this Assignment in the Portfolio

Medication errors can cause thousands of injuries and cost millions of dollars per year. Prevention of medication errors by eliminating some of the common causes for them is one way to cut down on injury and added healthcare costs. This assignment which tackled the medication error issue by identifying ways to improve on them proves strength that myself and group members are able to critically think and come up with solutions to healthcare issues.

• Critical Thinking

  o Uses decision-making skills in making clinical or professional judgments

    ▪ By identifying solutions to prevent medication errors outlined in this assignment, the group was able to make clinical and professional judgments to decrease the risk of medication errors in the workplace.

• Nursing Practice

  o Establishes and/or utilizes outcome measures to evaluate the effectiveness of care

    ▪ In this assignment we identified a way to measure outcomes of a trial run of a new way of practicing in healthcare delivery systems to prevent medication errors. Before a change effects the whole hospital system, a trial run is a great way to evaluate whether or not a new standard of practice is feasible or whether it needs to be altered at all before changing the standard of practice for the whole hospital. This way, users that deal with the change directly can offer input on whether it works for them or not - and fix issues before it is too late.

• Teaching
• Uses information technologies and other appropriate methods to communicate health promotion, risk reduction, and disease prevention across the lifespan.

  - By improvising a new plan for decreasing medication errors we can decrease the risk of associated injuries and increased medical care costs with medication errors.

  - By using the same medication reconciliation safety check system throughout the hospital, it ensures that all patients will be given the same standard of care by having their medications checked safely by healthcare professionals.

• Research

  - Evaluates research that focuses on the efficacy and effectiveness of nursing interventions

    - This group researched possible solutions to the problems associated with medication errors and found that solutions such as double checking medication reconciliations, having improved communication between healthcare professionals as well as safe legible prescriptions can decrease risks with medication errors. By implementing these solutions into our proposed plan we can then test them by piloting the new plan to decrease medication errors. We can then evaluate that the solutions were beneficial by comparing the numbers of medication errors prior to the change to the number of medication errors after the change.

• Leadership

  - Assumes a leadership role within one’s scope of practice as a designer, manager and coordinator of health care to meet special needs of vulnerable populations in a variety of healthcare settings

    - By leading healthcare to safer ways to handle medications and prevent medication errors, the healthcare environment will become a safer place. The plan in this particular project was to first pilot the new medication management system on one unit of the hospital before making it a change in the whole entire hospital. This is to identify whether the new plan would work and gives time to alter plans for other parts of the hospital that may have different needs based on the population of patients that they serve.

• Professionalism

  - Advocates for professional standards of practice using organizational and political processes

    - This group advocated for improved standards of practice by researching and identifying solutions to decrease medication errors in from occurring. A proposed way of testing out a new way of medication reconciliation was made
by the group based on research and a plan to execute the new standard of practice in a hospital setting would be improvised using an organizational process. A pilot study would be completed first to make sure the plan works and also to work out any issues with the plan before the new standard of practice would go into effect hospital wide. If the plan worked for one organization, the idea could be pushed out to educate others in other hospital systems.