

Collaborate on Quality: Issue Analysis & Leadership Action Plan

Posted on October 9, 2024

The primary concern of healthcare is to ensure high-quality services in its dynamic landscape for the betterment of general public. In this context, owing to my recent position as “quality manager”, the paramount responsibilities bear soothing rewards along with massive challenges. Such an administrative role requires hard work to address existing deficits and also proposing measures for patient safety and enhance quality. In other words, it requires cultivating a profound environment where quality and safety are reflections of healthcare organizations. The transformative changes are key elements to prove the incredible role of quality managers like influential leadership slots. However, the particular incidents may aggravate a culture embedded with fairness and justice leading to systematic improvements. In this aspect, the way forward may linger on with the core principles of Continuous Quality Improvement (CQI). These fundamental principles provide a basic framework to craft a precise and practical leadership plan of action. The main glimpses of such a plan of action explore a comprehensive collaboration among leaders, departments, quality managers and stakeholders to weave a holistic approach for enhanced quality. Meanwhile, this paper will explore main transformative changes, a quality manager must adopt in a healthcare organization for Continuous Quality Improvement (CQI). In addition, it delves into comprehensive analysis, objectives of fostering a culture, leadership strategies, and overall approach for patient safety and quality improvement.

Issue Summary:

In recent past, an incident took place in my hospital at pediatric unit. Two patients have similar identification concerning their names along with their dates of birth. Patients 1 & 2 (Siphlin having DOB as 12-04-2023) proved very problematic on the hospital database as well in the same unit.

Key Elements of the Issue concerning the Incident:

- The respective manager should take mandatory steps in the light of the patient safety officer’s information and chalk out a clear plan of action to resolve the issue and also adopt measures to mitigate such incidents in future.
- The healthcare organization is not adorned with a framework to deal with identical patient cases who are admitted in the same unit.
- The healthcare organization could not adopt such troubleshooting channels for addressing the risk of such incidents.

Patient Safety Goals – Reducing Risk on Identical Patient Cases:

- The primary goal is to establish such a culture to ensure the safety of the organization. The main features may include acknowledging the risk, collaboration among staff, prevention of errors, systematic resolutions of problems and continuous approach towards patient safety within the organization (Brborović et al. 2022);
- Creating such an advanced system to identify and address identical patients in the unit.
- Devising such a comprehensive system to involve department units and organizations to address issues systematically with the help of human resources.

Culture

In the setups of organizations, culture may deem an entity encompassing beliefs, shared values, adopted behaviours, practising norms and overall attitudes that shape all those ways regarding which individuals of such organization interact and function (Osman et al., 2019). It formulates a huge platform for improvised decision making, overall actions and communication patterns. Hence culture remains the profound entity for quality and safety that renders long-lasting influences to overcome challenges. So, a positive culture adorned with safety and quality becomes a necessary part of routine operations within an organization. In this context, the exiting cultures of any organization may hinder or facilitate safety along with quality depending upon features and traits of the culture. As far as my organization is concerned, the culture needs massive transformative changes for improved quality and safety concerns. The existing culture mainly stifles employee input, has a main focus on productivity and sometimes compromises critical dimensions, especially the transparency in its functions and actions.

Meanwhile, to cultivate a profound culture of safety and improved quality, multiple evidence-based strategies are mandatory to be implemented. One such strategy is leadership engagement which plays a core role in shaping the organizational culture (Roscoe et al., 2019). Regular communication from leadership slots, actively participating in safety measures and exemplary leading spirit pose a lasting impact on culture. Similarly, another strategy is psychological safety which suggests crucial practices for spotting and proposing improvements. When employee slots are confident enough about the resolution of their issues and concerns, they must intend to identify and resolve the safety and quality concerns. Such fostering can be acquired through workshops, open discussion forums, vigilant policies and good-faith reporting of incidents.

IHI Triple Aim

- A comprehensive framework formulated to set precise goals by the Institute for Healthcare Improvement (IHI) for quality-based healthcare delivery is called the IHI Triple Aim. Simultaneously, this aim seeks three key objectives to be achieved on priority. These may include improvement in the health of the populace, improving care experiences of the patient community and finally lessening per capita expenses of the healthcare industry (Crowder, 2019). Application of the IHI Triple Aim to the said incident of identical patient recognition may involve multiple approaches. Such an incident may lead to medication error that eventually results in medication error. Addressing this safety issue IHI Triple Aim can be engaged in multifaceted manners. The first approach regarding the incident tends towards side effects and severe reactions to the wrong medication. The development of various interventions may prevent such errors in future times for enhancing health outcomes. Similarly, the incident may pose anxiety and stressful situations for the patient and the respective family. In this context, various strategies like patient-centred communication encompassing in-time and transparent updates. In such scenarios, organizations must have departments or employees who console the patient's concerns and also provide emotional backup. Additionally, safety deficiencies in the given scenario leading to medication errors will eventually substitute for enlarged hospital stays, extra treatments and more rigorous tests. All such discrepancies result in high healthcare costs. However, identifying and mitigating all such causes to increase healthcare expenses may reduce the cost manifold.
- Meanwhile, several strategies may be adopted to incorporate IHI Triple Aim elements into the organization. The foremost strategy is to manage the population's health by actively identifying high-risk patients to prevent any medication error. Similarly, patient slots can be empowered by spreading awareness and educating them concerning shared decision-making. Such initiatives and their implementation should be patient-care-centric. Additionally, the incorporation of modern technology for resource allocation and medication management systems may reduce the financial burden on patients. Such a strategy can ensure cost-effective delivery of healthcare facilities to the general masses on equal pacing.

Leadership & Collaboration Strategies

- Safety and quality culture can be fostered within healthcare organizations by engaging in collaborative strategies and an evidence-based leadership practices. Such key leadership standards pose lasting impacts on patient care. For the establishment of such a marvelous culture, various departments and particular leadership slots must be involved in the action process. In this context, several departments that may be involved to actively participating in such incidents are nursing, pharmacy and quality control cells. Nursing is highly obliged with due care in risk incidents while pharmacy is directly involved in medication error incidents. However, quality assurance facilitates impactful communication and devises profound analysis

of the situation.

- Similarly, for clear and successful plan implementation, the involvement of particular key personnel is significant. These may encompass senior leaders like the Chief Nursing Officer (CNO), frontline staff members like experienced nurses and clinical experts for accurate medication and dosage. It is pertinent to mention that non-engaging the relevant departments and staff may lead to drastic results. It may mitigate the holistic approach to resolve the issue and deprive collective responsibility to ensure safety and quality culture. On the other hand, if the relevant departments and official leaders are involved in such incidents, it may lead to resolving the issue on priority and things would not get worse (Roscoe et al., 2019). However, various leaders may play different roles in handling the situation. For example, senior leaders like CNO may encourage the lower staff's active participation and rectify any type of barriers. Similarly, registered nurses, frontline officers, pharmacists and CMOs play a major role in following and practising standard protocols to ensure the safety of the patient.
- Moreover, several best practices can be enlisted for aid to enhance safety and quality within the healthcare organization along with mitigate the risk in future, these may encompass as:
 - Clarified and efficient communication
 - Profound decision-making
 - Approaches based on available data
 - Strict coherence with organizational goals

Leadership Action Plan

- An evidence-based leadership plan of action becomes mandatory to promote safety and quality culture in the healthcare organization. Such a plan of action may comprise specific strategies and broad-spectrum practices to improve the overall situation of healthcare organizations. In this context, the main evidence-based leadership strategy may be entitled as transparent communication.
- This plan should encompass both specific strategies to address the incident and broader best practices for organizational improvement. It is crucial for leadership slots to communicate the incident and its details to all the concerned stakeholders. Such communication may involve clarity of the situation, demonstration of errors and future planning to reduce such discrepancies (Mendy et al., 2020). Similarly, another leadership strategy revolves around team cooperation and respective rigorous training. The formulation of a multidisciplinary team excellently analyzes the incident and comprehensive training enables the members to devise techniques for resolution. Such collaboration and diverse expertise enable the system to adopt preventive measures in the best possible way. Additionally, the prevailing culture of accountability and fairness may contribute to resolving such flaws in the system over time. Leaders are highly expected not to punish the personals regarding honesty or good intentions but encourage them to report any incident.
- Moreover, best evidence-based practices may help to improve the safety and quality of the healthcare organization, one such practice is the implementation of standardized protocols and

procedures for high-risk incidents like medication errors. These clear guidelines reduce the harms and promote minimized error occurring to mitigate any severe damage to patients. Similarly, another practice in this regard is monitoring and evaluation leading to continuous feedback. For such practice, the application of modern technology must be improvised to promote the culture of vigilance and safety matrices in the healthcare organization. Finally, the best leadership practice is learning from errors. Sufficient resources must be allocated to facilitate the stakeholders to devise such a framework that prevents errors in the future.

Opportunities to Enlist Governing Board

- The direction, policies and healthcare institute strategies are governed by the organization's governing board. The board plays a pivotal role in delivering safety and quality within the healthcare organization. It demonstrates necessary ethical guidance, efficient patient care and regulatory protocols. Meanwhile, the governing board may foster a fair and justice-based culture through multiple approaches. These may encompass as:
- Regular updating and providing reports on safety incidents to the governing board
- Presenting data-based insights adorned with facts of the events and demonstration of the organization's overall progress.
- The sessions of educational workshops may provide deep insights into the challenges in the line of promoting safety and fair culture.
- Incorporation of safety goals and quality measures for strategic planning to align organizational priorities for healthcare improvement.
- Similarly, to enhance the governing board's involvement, some extra and additional information may become helpful. For example, benchmark data of healthcare organizations may be compared with other organizations on the parameters of safety and quality functions. In addition, details of financial implications may demonstrate the effects of errors on patient outcomes. Such additional information may include the details of available and allocated resources for safety and quality improvements. Meanwhile, the additional information relating to the evolution and updates of regulatory standards plays a significant role in ensuring safety and quality within the healthcare organization.

Conclusion

From the above discussion, it can be concluded that safety and quality culture in any healthcare organization are significant. The particular incident of identical patients in the unit of my hospital site needs an urgent and comprehensive leadership plan of action. In this context, the role of quality manager requires to exploration of evidence-based strategies and best practices revolving around transparency, cooperation and improving continuous quality themes in the healthcare organization. Meanwhile, the IHI Triple Aim framework provides enhanced patient experiences along with cost-effective healthcare facilities and improves the health of the general populace. These may mitigate

the incidents leading to medication errors in the future. Further, the profound role of the governing board is of prime significance, especially in shaping quality and safety aspects within healthcare organizations, the updated and relevant data in alliance with educational insights, quality initiatives and active contribution of justice-based protocols may enhance the efficiency of the board. Additionally, the collaboration of departments and stakeholders along with engaging the leaders from different quarters may reduce the bad impacts of such errors and incidents. Hence it is the need of the hour to adopt these strategies to mitigate the occurrence of such incidents in future.

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