

Utilizing the Salinas (2017) article #1, Mascioli, Carrico (2016) article #2, Easter, Tamburri (2018) article #3 and Zerwekh (chapter 22) textbook, answer the following questions.

1. What is Quality Improvement (QI) and what are some reports used to track QI? Quality Improvement is the process or activities that are used to measure, monitor, evaluate, and control services, which will lead to measurable improvement to health care consumers. Some of the reports used to track QI are incidence or variance reports.
2. As stated in the Salinas article, what does HCAHPS stand for and what individuals may not receive the HCAHPS survey? What is the purpose of the surveys and how does it link to Value Based Purchasing?

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS). People that do not get the survey are patients that do not have Medicare. The purpose of the survey is to determine which hospitals are properly taking care of their patients, and as a result, the scores they received determine the amount of financial reimbursement that the hospital will receive.
3. According to Salinas, what did the findings from this study confirm? What are some of the initiatives hospitals have incorporated to improve value and outcomes for patients? What areas of high HCAHPS ratings were found to lower readmission rates and decrease rates of mortality?

The study found out that hospitals with higher levels of satisfaction on the survey had lower rates of readmission. Some of the initiatives that hospitals have incorporated are linking the hospital reimbursement back to the amount of money the employees receive as a bonus. Places with high quality of care and satisfaction were found to have lower readmission rates and decreased rates of mortality.
4. In the National Patient Safety Goals article, what is the purpose of NPSGs? What questions are to be addressed by hospitals regarding safely managing alarms? What are the preexisting NPSGs?

The purpose is to improve patient safety by applying evidence and expert based solutions to high-risk, problem-prone areas with a significant risk to patient safety and the potential for patient harm. Some of the questions to be asked are: what are the clinically appropriate settings for alarm signals, when care alarm signals be disabled, when care alarm parameters be changed, how are alarm signals monitored and responded to, etc. The preexisting NPSGs are: improve the accuracy of patient

identification, improve the effectiveness of communication among caregivers, reduce the risk of healthcare-associated infections, and improve the safety of using medications.

5. What are the four categories that core measures are divided into? How many core measures are there?

The four categories that core measures are divided into are: Acute Myocardial Infarction, Heart Failure, Pneumonia, and the Surgical Care Improvement Process. There are 33 core measures.

The following questions will be answered from the Understanding Patient Safety and Quality Outcome Data article:

1. What are the seven groups of measures used to calculate hospital ratings? Where are these measures posted?

The seven groups of measures are used to calculate overall hospital ratings are: mortality, safety of care, readmission, patient experience, effectiveness of care, timeliness of care, and efficient use of medical imaging. They are posted annually on the Hospital Compare website.

2. What are the common nursing-sensitive indicators?

They are: pressure injury, falls and falls with injury, hospital-acquired infections, and patient satisfaction with nursing care.

3. What is the difference between process measures and outcome measures?

Process measures assess the interventions provided by the health care team, while outcome measures provide evidence of the effect of the interventions.

4. What is meant by mean, median, and mode?

The mean is the sum of all values in a data set divided by the total number of values. The median is the midpoint of a data set. The median is most often used to characterize a data set when extreme values or outliers are included. The mode is the value in the data set that occurs with the greatest frequency. The mode is rarely used to compare quality and safety outcome data.

5. What is benchmarking?

Benchmarking is the process of comparing outcome measures among hospitals or individual units.

6. What is the purpose of analyzing outcome data and comparing performance to external benchmarks?

The purpose of analyzing outcome data and comparing unit or organizational performance to external benchmarks is to identify outcomes that need improvement and implement best practices to ensure that patients are receiving the safest and highest-quality care.

7. Name all the phases in the PDSA cycle and give a brief description of each phase.

Phase 1: Plan - Start with 1 outcome that needs improvement. Focus on one change instead of many things at once.

Phase 2: Do - Implementing any change requires all team members to be well informed of their role in, and the reasons for, the new practice. Get all members on board.

Phase 3: Study - Comparing data before and after a change enables nurses to determine the effectiveness of the new practice.

Phase 4: Act - There are 3 primary options: adopt, adapt, or abandon the new change.

Critical thinking Box 22-2 (Zerwekh, 2018)

Your nursing unit has experienced a problem with the IV tubing not being labeled to show when it needs to be changed. You are the QI nurse who must collect data for a process improvement project. The nurse manager has asked you to determine baseline data for a month and report your findings to her.

1. How would you go about doing this?

I would first create a document to hold all of the information that I gather. I would visit each room on the unit and mark whether or not the IV tubing had a label or not. After a month, I could calculate the finding and determine how the complicate rate was for the unit.

2. What would be your indicators?

The indicator would be the IV tubing labeling. This is the problem that is being further investigated to check for policy compliance.

3. What would be the metrics?

Metric 1 - Rate of continuous flow IV tubing that has not been labeled with the date and time it needs to be changed.

Metric 2 - Rate of the intermittent flow tubing (IVPB) has not been labeled with the date and time it needs to be changed.

4. Pretend that you have some results after a month. How will you report the information to the manager?

I would show my manager the document that I created and the result that I had found each day during that month. I would discuss what ways that we could increase the compliance with adding labels to the tubing, and see what she thinks would be the next course of action to take.