Quality Patient Care: Z- CH 22

1) What is Quality Improvement (QI) and what are some reports used to track QI?
    a) Quality Improvement is the proactive, systematic approach to analyze processes to ensure safety of care and performance, and prevent future incidents from occurring.
    b) Reports to track QI are called incidence reports, QI reports, 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?
    a) HCAHPS stands for: the Hospital Consumer Assessment of Healthcare Providers and Systems.
    b) Individuals who may not receive the HCAHPS survey are: younger than 18 at the time of admission, did not have one overnight stay as an inpatient, had a psychiatric diagnosis upon discharge, and those who are not alive at discharge.
    c) The purpose of the surveys is to get the patient's perspective and satisfaction of the care they received while in the hospital. It links to VBP in that hospitals are reimbursed for better HCAHPS scores. It is a way to quantify patient experience through quality of care.

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?
    a) The findings from this study confirmed that hospitals with higher levels of patient satisfaction tended to have lower readmission rates and higher overall quality.
    b) Some of the initiatives hospitals have incorporated are: noise reduction, privacy, room reconfigurations for staff efficiency, and clustering of care.
    c) Areas of high HCAHPS ratings found to lower readmission rates and decrease rates of mortality are: nurse communication, pain management, and cleanliness/quietness.

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?
    a) The purpose of NPSGs 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.
    b) Questions to be addressed by hospitals regarding safely managing alarms are:
        i) What are clinically appropriate settings for alarm signals
        ii) When can they be disabled
        iii) When can parameters be changed
        iv) Who has the authority to set or change alarm parameters
        v) How are alarm signals monitored and responded to
        vi) How are individual alarm systems checked to ensure accurate settings, proper operation, and detectability
        vii) How should staff be educated about the purpose and proper operation of alarm systems for which they are responsible?
    c) Preexisting NPSGs
        i) Improve accuracy of patient ID
        ii) Improve the effectiveness of communication among caregivers
        iii) Improve the safety of using medications
        iv) Reduce the risk of HAIs
5) What are the four categories that core measures are divided into? How many core measures are there?

a) Five categories:
    i) Promotion of measurement that is evidence-based and generates valuable information for quality improvement
    ii) Consumer decision making
    iii) VBP and payment
    iv) Reduction in the variability in measure selection
    v) Decreased provider's collection burden and cost
b) There are 8 core measure sets.
    i) ACOs, PCMH, and primary care
    ii) Cardiology
    iii) Gastro
    iv) HIV and Hep C
    v) Medical Oncology
    vi) OB/GYN
    vii) Orthopedics
    viii) Pediatric

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Core-Measures.html

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?
    a) Mortality, safety of care, readmission, patience experience, effectiveness of care, timeliness of care, and efficient use of medical imaging.
    b) Posted on the hospital compare website
2) What are the common nursing-sensitive indicators?
    a) 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?
    a) Process measures: assess the interventions provided by the health care team
    b) Outcome measures: provide evidence of the effect of the interventions
4) What is meant by mean, median, and mode?
    a) Mean: sum of all values in a data set divided by the total number of values
    b) Median: midpoint of a data set, half values above and other half below
    c) Mode: the value in the data set that occurs with the greatest frequency
5) What is benchmarking?
    a) 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?
    a) In order to assess one's own performance, evaluate it against that of high performers, and identify improvement opportunities. It can identify organizations' successful practice, which can then be tested in organizations striving for improvement
7) Name all the phases in the PDSA cycle and give a brief description of each phase.
    a) Plan: start with one outcome that needs improvement and apply root cause analysis; formulate plan that addresses the discovered root cause
    b) Do: Implement the change and obtain feedback on difficulties or barriers. Data collection and track process measures.
    c) Study: Compare data before and after the implemented change to determine effectiveness.
    d) Act: Adopt, adapt, or abandon and/or repeat PDSA cycle if necessary.

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?
    a) Create a team to assess and evaluate labelling of IV tubing
2) What would be your indicators?
    a) Indicators would be IV tubing without a label to show when it needs to be changed
3) What would be the metrics?
    a) The number of incidences where IV tubing isn't labelled with the date it needs to be changed.
4) Pretend that you have some results after a month. How will you report the information to the manager?
    a) I would create a spreadsheet with the necessary calculated numbers after the month.