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Journal 8

Maintaining a safe environment was the topic this week. A culture of safety promotes openness and error reporting, which results in fewer adverse events. Risk management identifies and prevents adverse events or hazards and tracks the occurrence of negative clients' incidents. There are many cultures of safety, they include service occurrences, near misses, serious incidents, sentinel events, and failure to rescue. Service occurrence relates to client services and can include a slight delay in service or an unsatisfactory service. Near misses is when a negative outcome almost occurs but is caught before it affects the client. Serious accidents include minor injuries, loss of equipment or property, or significant service is interrupted. A sentinel event is an unexpected death or major injury, whether physical or psychological, or situations where there was a direct risk of either of these. Failure to rescue is the most severe and describes a situation where a client develops a complication that leads to death. Failure to rescue is a well-established issue in patient safety healthcare quality. Rapid response systems are hospital-based systems to detect and treat deteriorating patients before adverse events occur. Patient monitoring involves assessment of various vital signs and psychological changes (Hall, 2020). Monitoring criteria are then used to help guide activation of the rapid response team (Hall, 2020). This week's material was easy for me to understand due to my experience in working at hospitals with safety plans. The most challenging thing for me this week was ensuring that I read the book thoroughly for the upcoming exam.

Reference

Hall, K. (2020, March 2). *Failure to rescue*. Making Healthcare Safer III: A critical analysis of existing and emerging patient safety practices [Internet]. Retrieved November 8, 2021, from https://www.ncbi.nlm.nih.gov/books/NBK555513/.