Improvement Plan Tool Kit

Learner's Name

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Improving Quality of Care and Patient Safety

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This improvement plan tool kit aims to enable nurses to implement and sustain safety improvement measures in health care settings in a geropsychiatric unit. The tool kit has been organized into four categories with three annotated sources each. The categories are as follows: general organizational safety and quality best practices, environmental safety and quality risks, staff-led preventive strategies, and best practices for reporting and improving environmental safety issues.

Annotated Bibliography

General Organizational Safety and Quality Best Practices

Sherwood, G., & Horton-Deutsch, S. (2015). Reflective organizations: On the front lines of QSEN and reflective practice implementation. Retrieved from https://ebookcentral-proquest-com.library.capella.edu/lib/capella/detail.action?docID=3440207#

This e-book presents the paradigm shift required for organizations to provide QSEN (quality and safety education to nurses). It provides readers with the innovative pedagogical approaches required to change traditional content-based health care education methods to interactive methods that engage learners. These approaches include facilitative teaching, visual thinking strategies, creating a presence that is authentic, and meaningful learning through debriefing. Concrete examples in the resource demonstrate the application of reflective learning. Additionally, the reflective questions in the resource guide readers to evaluate their own practice, either independently or in groups, to implement formal education programs with a focus on self-improvement. The resource prepares nursing students for advanced competency,

which will help them adopt reflective thinking, develop a safety culture, and therefore qualitatively improve practices in critical health units such as geropsychiatry units.

Fleiszer, A. R., Semenic, S. E., Ritchie, J. A., Richer, M.-C., & Denis, J.-L. (2016). A unit-level perspective on the long-term sustainability of a nursing best practice guidelines program: An embedded multiple case study. *International Journal of Nursing Studies*, *53*, 204–218. https://doi.org/10.1016/j.ijnurstu.2015.09.004

This article helps analyze the sustainability of a best practice guidelines program implemented in acute health care settings. The sustainability of the program was characterized by the following: benefits for patients as the rate of incidence of falls reduced; routinization of best practices as the team's adherence to guidelines improved; and, in the long term, the development of the team's adaptability to changes in circumstances that threatened the program. Seven key factors that accounted for the sustainability of the program were also identified. The source explains how relationships between the characteristics of sustainability (benefits, routinization, and development) and the seven key factors contributed toward the sustainability of the improvement program. This source is valuable for nursing students as it helps them understand how safety programs can be sustained to ensure the long-term reduction of the incidence of sentinel events in geropsychiatric units.

Kossaify, A., Hleihel, W., & Lahoud, J.-C. (2017). Team-based efforts to improve quality of care, the fundamental role of ethics, and the responsibility of health managers: Monitoring and management strategies to enhance teamwork. *Public Health, 153*, 91–98. https://doi.org/10.1016/j.puhe.2017.08.007

This paper discusses the benefits of teamwork in improving the quality of health care. It presents a review of 33 papers identified after performing a search on PubMed. The paper discusses the important ingredients of efficient teamwork such as self-awareness and the individual behavior of team members, the ethical climate within the team, the work environment and institutional infrastructure, positive moderation from leadership, and communication and coordination among team members. Effective teamwork can help reduce the incidence of sentinel events that result from preventable medical errors, which are often caused by dysfunctional communication among team members. Teamwork is more reliable and efficient than individual work in high-risk environments such as a geropsychiatry unit. Although the specific contexts of readers' practices may be different, this resource is valuable for nursing administrators and professionals as it discusses the implementation of values needed for positive teamwork as well as the monitoring and management of teamwork.

Environmental Safety and Quality Risks

Powell-Cope, G., Quigley, P., Besterman-Dahan, K., Smith, M., Stewart, J., Melillo, C., Friedman, Y. (2014). A qualitative understanding of patient falls in inpatient mental health units. *Journal of the American Psychiatric Nurses Association*, *20*(5), 328–339. https://doi.org/10.1177/1078390314553269

This source mentions a study conducted to analyze falls in geropsychiatric patients. The study also focused on selling falls prevention in psychiatric units. The risk factors that lead to the falls were identified by a focus group. The focus group formulated an improvement plan to reduce the number of falls, and it was found that implementing

infrastructural changes such as the use of geriatric-friendly sanitary ware such as raised toilet seats helped reduce the rate of incidence of falls. Although all the changes may not be feasible in a given setup, many of the strategies mentioned in this study could serve as a starting point for the prevention of falls. The article helps nursing students understand the challenges that occur in an adult mental health unit and the quality improvement measures taken to resolve these challenges.

Wong Shee, A., Phillips, B., Hill, K., & Dodd, K. (2014). Feasibility, acceptability, and effectiveness of an electronic sensor bed/chair alarm in reducing falls in patients with cognitive impairment in a subacute ward. *Journal of Nursing Care Quality, 29*(3), 253–262. https://doi.org/10.1097/NCQ.0000000000000054

This source is a preliminary study conducted to determine the effectiveness of electronic sensor bed/chair alarms to reduce the occurrence of falls in patients with cognitive impairment. These alarms can be attached to the patient's body or to the bed/chair the patient uses to alert the nursing staff every time the patients move or leave their seat. Nurses were educated about the alarms and asked to document their observations and provide feedback. Although effective at preventing falls in patients with cognitive impairment, the electronic sensors needed improvements such as the elimination of cords that may be hazardous to patients and the additional provision of alerting nurses through pagers. This source helps nursing students understand both the effectiveness and the limitations of electronic sensor alarms in reducing the occurrence of falls.

Chari, S. R., Smith, S., Mudge, A., Black, A. A., Figueiro, M., Ahmed, M., . . . Haines, T. P. (2016). Feasibility of a stepped wedge cluster RCT and concurrent observational sub-

study to evaluate the effects of modified ward night lighting on inpatient fall rates and sleep quality: A protocol for a pilot trial. *Pilot and Feasibility Studies, 2*(1). https://doi.org/10.1186/s40814-015-0043-x

Inadequate lighting at night in geropsychiatric wards is one of the important causes of falls in geropsychiatric units. Psychotropic medications can cause cognitive impairments and blurring of vision, which can be aggravated by dim lighting in the units. The article presents a trial pilot study conducted to evaluate the effects of the use of modified night lighting in inpatient wards to prevent falls. LED lights were installed in the vicinity of the beds and the toilets, where falls were likely to occur. The study provides valuable insights that could inform design and refurbishment efforts at geropsychiatric units. An important limitation of the study is that a stepped wedge, cluster randomized controlled trial has not yet been applied to test environmental modifications in any setting. However, the modifications discussed could still be implemented as an important intervention strategy for preventing falls in older adults with cognitive impairment.

Staff-Led Preventive Strategies

Morgan, L., Flynn, L., Robertson, E., New, S., Forde-Johnston, C., & McCulloch, P. (2016). Intentional rounding: A staff-led quality improvement intervention in the prevention of patient falls. *Journal of Clinical Nursing, 26*(1–2), 115–124. https://doi.org/10.1111/jocn.13401

This article highlights an intervention strategy called *intentional rounding* to reduce the occurrence of inpatient falls. Intentional rounding is a specific strategy in which nurses conduct a routine check on patients at certain time intervals based on the needs of the

patient. The rounding was implemented through effective communication and teamwork among the nursing staff and iterations of plan-do-check-act measures. This proactive staff-led strategy helped reduce the rate of falls by 50%. This study achieved success through the combined efforts of the research team that conducted the analysis of the system to design the rounding format and the frontline nursing staff who conducted the intentional rounds. Although its sample size was small and not entirely representative, the study does establish intentional rounding as an effective falls-prevention strategy, which when implemented with adequate staff engagement and support from leadership definitively reduces the occurrence of falls.

Moncada, L. V. V., & Mire, G. L. (2017). Preventing falls in older persons. *Am Fam Physician, 96*(4), 240–247. Retrieved from https://www.aafp.org/afp/2017/0815/p240.pdf

The article posits that a history of falls in older persons is associated with an increased risk of a future fall. The American Geriatrics Society recommends that older adults aged 65 and above should undergo annual screening for balance impairment and a history of falls as a preliminary intervention for the prevention of falls. The article also highlights an algorithm developed by the Centers for Disease Control and Prevention. The algorithm suggests assessment and multifactorial interventions to prevent falls in patients who have had more than two falls and more than one fall-related injury. The multifactorial interventions include exercise routines that include balance and gait training, the use of vitamin D supplements with or without calcium based on the community in which the patients dwell, and the management of psychotropic medication. These interventions have been known to cause a significant decrease in the rate of falls

and can be implemented across all geropsychiatric wards to prevent sentinel events. The source is authentic and hence can be referred to by nursing students to understand multifactorial interventions in the prevention of falls.

Isaac, L. M., Buggy, E., Sharma, A., Karberis, A., Maddock, K. M., & Weston, K. M. (2018). Enhancing hospital care of patients with cognitive impairment. *International Journal of Health Care Quality Assurance*, *31*(2), 173–186. https://doi.org/10.1108/IJHCQA-11-2016-0173

This paper evaluates the TOP5 intervention strategy of improving patient care. The strategy involves engaging with carers of geriatric patients (individuals who are family members or friends of the patients) to collect characteristic non-clinical information about patients to personalize care and reduce falls. The carers of patients narrated to the nursing staff five important and distinct characteristic details such as the patients' needs and past emotional experiences. The nursing staff then prepared a customized plan of care for each patient based on this information. This study reported a significant reduction in falls and qualitatively improved care. The study enables nursing students to meaningfully involve the carers of cognitively impaired patients and reduce the incidence of falls.

Best Practices for Reporting and Improving Environmental Safety Issues

Tan, A. K. (2015). Emphasizing caring components in nurse-patient-nurse bedside reporting. *International Journal of Caring Sciences, 8*(1), 188–193. Retrieved from https://library.capella.edu/login?qurl=https%3A%2F%2Fsearch.proquest.com%2Fdocview%2F1648623547%3Faccountid=27965

This source provides a review of strategies that improve bedside reporting and transfer of duties after a change of shift among nursing staff. The source also emphasizes team engagement that can help reduce the incidence of sentinel events, especially in health care units such as geropsychiatry units. Bedside reporting is a vital concern in geropsychiatric units as patients are prone to behavioral changes and unpredictable behavior may affect other patients in the unit. During a shift change, the nursing staff can alert the incoming staff about the condition of such patients to proactively prepare the staff to address any forthcoming issue. Barriers to bedside reporting were also analyzed, and barriers perceived by patients and those perceived by nurses were identified. These barriers can be eliminated through open communication and by educating the nursing staff. The article provides a valuable discussion of factors that influence bedside reporting such as patient-centered care philosophy, guidelines of the Joint Commission Institute, demand for patient participation in making health care decisions, and the shortcomings of traditional handover practices.

Stergiopoulos, S., Brown, C. A., Felix, T., Grampp, G., & Getz, K. A. (2016). A survey of adverse event reporting practices among US healthcare professionals. *Drug Safety*, *39*(11), 1117–1127. https://doi.org/10.1007/s40264-016-0455-4

This article highlights the severity of underreporting of *adverse drug events*. An adverse drug event is defined by the World Health Organization as "a response to a medicine which is noxious and unintended, and which occurs at doses normally used in man." Adverse drug events are estimated to cause 7,000 deaths across health care settings in the United States each year. It is also said that half of these adverse drug events result from

preventable medication errors. The article also identifies factors that lead to the underreporting of the adverse drug events such as lack of training among health care professionals and standardized reporting processes. Underreporting of adverse drug events can be a critical problem, especially in health care units such as geropsychiatry units. Individual patients may react differently to psychotropic drugs; reactions may include overdoses or allergic reactions. These reactions need to be monitored closely and reported efficiently to avoid complications including falls. Nursing students can understand the importance of reporting adverse drug events through this source.

Lozito, M., Whiteman, K., Swanson-Biearman, B., Barkhymer, M., & Stephens, K. (2018). Good catch campaign: Improving the perioperative culture of safety. *AORN Journal, 107*(6), 705–714. https://doi.org/10.1002/aorn.12148

This article provides evidence-based results to show that the culture of safety in a perioperative unit was improved after implementing the good catch campaign. Good catch is the ability of nursing staff to point out mistakes and report them to avoid sentinel events. The campaign described in the article involves implementing a standardized electronic reporting system and debriefing process. The nursing staff discusses the plan of care for each patient at the end of the day during debriefing. This helps the nursing staff note characteristic risks involved with each patient and provide better care. Training nursing staff to implement the good catch campaign in health care units such as geropsychiatry units should enable the effective reporting of factors that could cause falls with a view to avoid them. This source enables nursing students to implement electronic reporting systems to report good catches and thereby reduce falls.

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