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Safety Culture and Quality Assurance in a Healthcare Organization

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Abstract

Ensuring the safety of patients is a fundamental priority of both patient care and quality management. The Beauchamp and Childress four principles of biomedical ethics represent one quality management paradigm that places a strong emphasis on the patient. The core of first-rate medical care is encapsulated in the Institute of Medicine's six improvement goals. The Triple Aim of the Institute for Healthcare Improvement is based on three key elements: care, money, and health. The aforementioned circumstances were taken into consideration when writing this review, which aims to highlight the system's actions to address numerous efforts to improve quality and patient safety. We offer a thoughtful summary of healthcare law, policy, and regulation, focusing on the concepts of informed consent and informed refusal. This report also describes the measures implemented and policies upheld by the management and administration to deliver patient-centered care. Lastly, we talk about example policies such as the Hospital-Acquired Conditions Reduction Program, which aims to lower hospital readmission rates, the Delivery System Reform Incentive Payment Program, which integrates quality management frameworks, and others.

Keywords: Quality management frameworks, IOM's six aims for improvement, IHI's Triple Aim, Patient safety.

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1. Introduction

The logistics of patient care and healthcare management are influenced by a number of issues, one of which is the optimization of high-quality care. A high standard of care is indicated by The Joint Commission's (TJC) accreditation, the Malcolm Baldrige National Quality Award's (MBNQA) performance excellence, and the Magnet Recognition Program's nursing excellence [1-3]. TJC is without a doubt the global leader in healthcare accreditation [4]. This non-profit organization can conduct an objective evaluation of quality performance in patient care and safety [4]. The nation's highest presidential award for effectiveness and quality is the MBNQA [5]. The Magnet Recognition Program was developed to identify and honor businesses worldwide whose nursing leadership has effectively matched nursing strategic goals to enhance patient outcomes [6]. Together with the previously described healthcare recognition, the Institute of Medicine (IOM) also uses its six aims for enhancement to categorize different aspects of care delivery [7]. The IHI created the Triple Aim, which attempts to improve population health, the standard of care, and the effectiveness of per-person healthcare spending. Here, we summarize the ways in which the Triple Aim, the Six Aims for Improvement, and biological ethics work together to put patient safety and improved care first. We'll discuss the clinical and managerial duties associated with guaranteeing patient safety in both urgent and everyday scenarios in this post. The purpose of this study is to provide an example of contemporary policies that support patient-centeredness while upholding standards that improve care, preserve quality, and increase safety. Because patient safety is essential to providing high-quality medical care, it is a top priority for all healthcare providers. Patients receive direct care from clinicians. Does this imply, however, that stakeholders such as legislators, executives, and managers are functioning independently of patient safety? The answer to the question above is "no" with great plausibility because these organizations develop and carry out policies to uphold and enhance patient safety in their own cities, institutions, and departments. Enforcing, adopting, and putting into practice macro-level healthcare policies created and advocated by legislators is the responsibility of micro-level leadership, management, and physicians.

2. Research questions and objectives

Among the quality management frameworks established by the corpus of current literature are the Triple Aim, the six objectives for improvement, and the principles of biomedical ethics defined by Beauchamp and Childress. All of the models discussed above encourage initiatives to improve healthcare delivery while also considering the needs and preferences of patients. But occasionally, patients who show up unconscious or intoxicated are unable to communicate their preferences for care.

Firstly, in light of the previously described situation, what are some safe harbors that medical professionals should consider while interacting with these patients? The second question is, "When a patient gives or withholds consent, what are the clinicians' options for how to proceed?" The second line of inquiry naturally leads to the third: to be more precise, what role does the administration play in implementing policies that aren't protected by current law? This analysis has three objectives. Initially, we aim to propose answers to the dos and don'ts that clinicians might use in emergency and non-emergency settings, based on the concepts of informed consent and informed refusal. Secondly, we aim to explain how hospital management could encourage patients to receive high-quality care while simultaneously reducing health hazards. Lastly, we look at model rules that have been recently put into place as a component of systemic efforts to uphold patient safety and encourage care delivery practices. These consist of the Hospital-Acquired Conditions Reduction Program, the Quadruple Aim, the Delivery System Reform Incentive Payment Program, and the Hospital Readmissions Reduction Program.

3. Literature review

Three well-known quality management frameworks that maintain patient safety are summarized here. The biomedical ethics concepts of Beauchamp and Childress. Promoting a culture of safety in patient care is a critical responsibility of medical and surgical faculty. Four biological ethics concepts apply in this situation. Among these ideals are "self-determination," "benefit," "non-harm," and "justice" [9]. Known as the "four pillars of medical ethics," these four principles form the basis of moral medical practice. Other facets of biomedical ethics that result from the aforementioned four principles are taken into consideration while making ethical medical and surgical decisions [10]. A summary of some of these extra features is provided below [10]. Integrity, Completeness of Information, and Privacy: Being truthful implies not distorting the facts while providing the patient with information about their medical condition, while full disclosure is delivering accurate and thorough information about that condition. Conversely, confidentiality pertains to the practice of maintaining the privacy of a patient's medical information [10]. Giving the patient complete power over all medical decisions is referred to as "autonomy" in this context. This idea is crucial to contentious issues such as end-of-life care and abortion [10]. The act of providing medical assistance to a patient with the least amount of harm is referred to as beneficence.

3.1. The Institute of medicine's six aims for improvement model

AHRQ Patient Safety Network defines harm prevention more broadly as "freedom from accidental or preventable injuries produced by medical care" [11]. The IOM also proposed six objectives for improving healthcare that would better meet patients' needs while ensuring their safety. The six goals are as follows [7]. Safe treatment is defined as not doing more damage than good to patients. Patient safety can become a system-wide strategy when patients witness policies that support a safe environment being embraced and implemented [7]. To be efficient, one must not squander any amount of money, time, resources, or energy. Healthcare waste includes, but is not limited to, defensive medicine, malpractice litigation, systemic complexity, and administrative fraud and abuse. Potentially enhancing cost-effective care and healthcare efficiency [7]. Efficient means making sure that a service is provided to everyone who could benefit from it. Making decisions about a patient's care based on the greatest available scientific data is known as evidence-based medicine [7]. Patient-centered care takes into account and attends to each patient's particular values, interests, and goals. If and only if the patient has agency over their own care, then care is patient-centered. This approach to patient care is innovative because it includes elements of communication and teamwork [7]. prompt: reducing needless waiting times for physicians and patients. When patients are kept waiting and there are dangerous delays, the overall quality of medical treatment may suffer [7]. Equity in healthcare refers to the provision of care that is consistent in quality and does not discriminate on the basis of demographic factors like gender, race, or socioeconomic status [7]. Getting healthcare providers to confirm the safety of their practices is the first of the IOM's six improvement goals. Second, patient care needs to be in line with recent research in order to be effective in the future. Third, when giving treatment, consideration is given to the patient's dietary restrictions, cultural background, and personal preferences. The hospice care provided to the terminally sick is based on the previously mentioned concept. Reducing patient wait times requires prompt delivery and receipt of services. Unexpected treatment delays carry a high risk of serious side effects for patients. But providing care on time is essential to guaranteeing patients' well-being. Fifth, reducing inefficiencies and duplications may ease the burden on healthcare resources that are already overextended. Lastly, therapy that is uniform irrespective of variables like financial situation, color or ethnicity, or income level is referred to as equitable care [7].

3.2. The Institute of healthcare improvement's triple aim model

The Institute for Healthcare Improvement (IHI) developed the Triple Aim approach, which accounts for care, cost, and health outcomes [8]. The three objectives of the IHI's Triple Aim approach are as follows [8]. Surveys such as the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) [12-13] can be used to monitor the degree of patient satisfaction with their care. Additionally, the National Practitioner Data Bank (NPDB) promotes high-quality medical care and aids in the prevention of healthcare fraud and abuse [14]. Individual healthcare costs can be decreased by taking steps like writing prescriptions for less costly generic pharmaceuticals rather than more costly name-brand ones [8]. fostering well-being in the community [8]. The IHI created the Triple Aim conceptual framework to describe a tactic with three related objectives. To do this, we must improve population health, raise the standard of treatment that people get, and reduce waste and variation in order to lower the cost of healthcare per capita.

The IHI's Triple Aim strategy can be utilized to reduce administrative responsibilities related to promoting and maintaining population health and wellness because of its wide applicability. The Triple Aim's first pillar, increasing the

experience of care, is where medical technology advancements that improve patient experiences with care fit in [8]. For example, telemedicine and telehealth program implementation helps with the second component. Telemedicine fills the gap with prompt, efficient care when medical professionals are unable to be there in person [8]. The potential for telemedicine to increase patient access to healthcare services is one of its advantages. Conversely, it clarifies this to medical professionals and patients who might not be acquainted with e-health. Improving population health, the third component of the Triple Aim, has bearing on making the first two objectives easier to achieve. As a result, the Triple Aim model of the IHI is a three-pointed framework, where the first two goals are necessary to achieve the third goal, which is to enhance population health [8].

4. Discussion

The adoption and application of best practices in both emergency and non-emergency situations are the duties of clinical faculty and administration in patient safety. Regardless of their insurance status or financial situation, all patients who visit an emergency room must be stabilized and treated under the federal Emergency Medical Treatment and Active Labor Act (EMTALA) [15]. Under EMTALA, doctors have an obligation to provide therapy to patients, and patients have a right to it [15]. In this context, consider an unconscious patient in the emergency room who feels uneasy about getting a blood transfusion. In the above hypothetical, was patient-centered care provided if the treating physician gave the comatose patient a blood transfusion to bring them back to consciousness without knowing the patient's preferred culture? The best place to look for the answer is most likely the provider's evaluation in the context of EMTALA. The assessment is primarily concerned with the clinician's legal obligation to treat every patient, particularly in emergency situations. In non-emergency situations, where patients and physicians have the autonomy to select the provider, the previously described hypothetical situation assumes a completely different dynamic. This is because a doctor-patient contract is predicated on the nature of the relationship between the two parties [16]. Contract law governs the doctor-patient interaction because the doctor has promised in writing to treat the patient in exchange for payment [16]. The physician is not legally required to treat a patient unless both parties sign a consent form [16]. "Informed consent" describes a stage in the delivery of medical care. Based on the words of American judge Benjamin Cardozo from 1914, "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault for which he is liable in damages," the idea of informed consent was born [18]. In order to handle the special circumstance that results when a patient refuses treatment in a non-emergency, the concept of "Informed Refusal" was created [19-20]. As an example of an informed refusal document, the patient will make a living will outlining their wishes for their final days of life [21]. In the previously described scenario, the healthcare professional honors the patient's desires regarding their final care and/or chooses not to treat them in line with their living will. Leadership entails enforcing EMTALA and helping physicians learn about informed consent and informed refusal procedures inside organizations. They also ensure that medical staff adhere to the previously specified patient preference policies. When laws do not already exist, leadership has the power to adopt rules in medical settings; nevertheless, they must use caution to ensure that these regulations do not conflict with public policy.

4.1. Prototype policies for macro-level patient safety programs in healthcare Program for delivery system change incentive payments: emphasizing adherence to quality management frameworks

Using the Triple Aim strategy and all six development goals, one prototype statute is the Delivery System Reform Incentive Payment (DSRIP) program. DSRIP has many healthcare projects that improve health statuses, with multiple metrics and milestones in primary care, specialized care, chronic care, navigation and case management, disease prevention and wellness, and general categories [23-24]. The State Department of Health consistently funds these programs when they are adopted by healthcare facilities [22–26]. There are four components to the DSRIP structure Infrastructure development, program innovation and redesign, quality improvement, and population health improvement in the states where its programs are conducted are the first four priorities [22–26]. In its third year of operation, the Texas DSRIP program's southeastern county region included about 172 projects in eight cohorts: primary care, emergency care, chronic care, navigation/case management, disease prevention and wellness, mental health/substance abuse prevention, and general [22-25] Each cohort's allotted number of projects entailed accomplishing patient care milestones and metrics were concurrently integrated with the IOM's six patient care goals: safe, effective, efficient, patient-centered, timely, and equitable [22–25]. DSRIP's ability to improve population health has been demonstrated by the implementation of all of its initiatives in the adopted counties and regions [25]. The DSRIP initiative employed the preventable hospitalization rate as one metric to assess the advancement of population health [24]. The decrease in hospitalization rates that could have been prevented could have been attributed to the DSRIP policy's underlying architecture and dynamics [23-24]. The interplay of healthcare externalities, incentive payment systems, forms of outcome reporting assessment, and physician-administrator collaboration were some of these processes [24]. In the approved regions and counties, a statistically significant decrease in avoidable hospitalization rates was observed when an interrupted time series approach was used to analyze the data [25]. There were two phases to the Texas DSRIP program: 1.0 and 2.0. Comprehensive Diabetes Care: in DSRIP 2.0, the eye exam metric increased by 16%, and in the latter, influenza vaccination increased by 12% [27]. The metrics for catheter-associated urinary tract infections (CAUTI), surgical infections (SSI), and central line-associated bloodstream infections (CLABSI) rates improved by 26%, 10%, and 9%, respectively, in DSRIP 2.0, according to research by Revere et al. [27].

4.2. Framework for the quadruple target: emphasizing the development of the triple aim

The Triple Aim was created in 2008 with three primary goals in mind: health, cost, and care. A fourth objective was developed in 2015 by Sikka and associates: improving the experience of providing care. This was done to acknowledge the importance of healthcare professionals—physicians,

nurses, and staff members—"finding joy and meaning in their work and thereby improving the experience of providing care " [28]. At the core of the fourth aim is the feeling of fulfillment and purpose that comes with giving care; thus, it is identical with achieving success and significance in their endeavors. The Quadruple Aim, which considers inclusivity for all members of the healthcare workforce, has significant consequences for philosophy and practice [28].

4.3. Program to reduce hospital-acquired conditions: emphasizing patient safety

The Hospital-Acquired Conditions Reduction Program (HACRP), a Medicare pay-for-performance project, supports the CMS's ongoing efforts to link Medicare payments to healthcare quality in the inpatient hospital context [29]. The National Healthcare Safety Network (NHSN) of the Centers for Disease Control and Prevention (CDC) measures healthcare-associated infections (HAIs), which include the following [30]. The following five types of blood stream infections are associated with central lines: (1) CLABSI; (2) CAUTI (catheter-associated urinary tract infection); (3) SSI (surgical site infection) related to hysterectomy and colon; (4) MRSA (methicillin-resistant staphylococcus aureus) bacteremia; and (5) CDI (clostridium difficile infection). Moreover, the program's eight Patient Safety Indicators (PSIs) consist of: Pressure Ulcer Rate (PSI 03), (2) Iatrogenic Pneumothorax Rate (PSI 06) (3) PSI 07: Bloodstream Infection Rate Associated with Central Venous Catheter, (4) PSI 08: Hip Fracture Rate Following Surgery, (5) PSI 12-Deep Vein Thrombosis or Perioperative Pulmonary Embolism Rate, (6) Postoperative Sepsis Rate, PSI 13 (7) PSI 14: Dehiscence Rate of Postoperative Wounds, (8) Accidental Puncture or Laceration Rate (PSI-15) [31].

4.4. Program to reduce hospital readmissions: emphasizing patient safety

Hospital Readmissions Reduction plan (HRRP), a Medicare value-based buying program, reduces payments to hospitals with excessive readmission rates. The project contributes to the national goal of improving healthcare by linking funding to the quality of hospital care [31]. In order to improve patient safety by reducing readmissions, HRRP is concentrating on the following problems [31]. These prerequisites are listed below [31]. Acute myocardial infarction (AMI), chronic obstructive pulmonary disease (COPD), heart failure (HF), pneumonia, surgery for a coronary artery bypass graft (CABG), and elective primary total hip and/or total knee arthroplasty (THA/ TKA) are the first six conditions [31].

4. Conclusions

The purpose of this review was to analyze patient safety via the lens of the previously described quality management frameworks. We specifically cited EMTALA, informed consent, informed refusal, and living wills as examples of laws and procedures. Getting the patient's informed permission is still required in non-emergency scenarios, even though the EMTALA laws still apply in those cases. It would be best to document the patient's informed decline of therapy if they choose not to proceed. We highlighted a few new prototype policies that are filtering up from national policymaking to institutional levels, with an emphasis on the steps the system has actively taken to improve patient safety and the quality-of-care delivery.

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