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Quality & Risk Management 1

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Answer to Question 1

The quality evaluation of nursing care is the main connection in the medical quality management. It is also necessary and worth reviewing them for the nursing supervisors who should understand the both advantages and disadvantages in the process of evaluating the quality of nursing care and improving the whole nursing quality.

Quality of care defined as the extent to which health care services provided to individuals and patients improve the desired health outcomes. And achieved through, safe health care, effective, efficient, equitable and people-centered.

The close relationship between the patient and the nurse describe the inputs of quality nursing care impacts the health outcomes of the patients including deal with the diseases and expected life type which would lead to the cure or best acceptable style of life if complain chronic symptoms

Quality nursing care: is part of quality in healthcare, there are a specified themes which demonstrates it summarized with six themes:

1-Advocacy: describe the nurse deal with the patient as a valuable person, protecting patient from medical and personal harm, asking physicians about patient needs of medical and clinical care treatment.

2-Empathy and Caring: nurse kindness with the patient while in clinical care and caring about his emotions, feelings, previous treatment experiences, and response to treatment.

3-Intentional care: nurse aiming to give the needed care in the best approach and practice which results in securing the patient management in a professional manner without any malpractice or delay or misuse of resources.

4-Patient Respect: Treating patients by professional respect will lead to exchange respect feeling, also respect the nursing job deeds on how to apply patient care. Patient is always worried about his future medical status, so try to get him calm and unworried by raising the trust which will result in good outcomes on patient satisfaction on the treatment delivered by the nurse.

5-Responsibility: It appears in providing the perfect and right nursing care through aware of nurse duties, roles and delegations in applying the patient care plan, and aware of emergency care issues and critical nursing skills which makes the patients feels comfortable and secured under nursing care. Responsibility have positive impact on the management plan which will lead to the good outcomes for the patient care.

Variables Measurement:

Variables have a direct role in the quality of nursing care, measured to evaluate its efficacy and efficiency, such as years of experience, competency skills, qualifications, experienced Health facilities, etc.

These five themes are measured through tools or systems which can address the healthcare outcomes for a nursing care plan procedures

For example, patient satisfaction questionnaire highlight all the concerns regarding patient experience through nursing care, including quality of care, time of services and responses for the patient need, daily patient follow up for medical tests and reports, reporting and dealing with emergencies during nursing care, applying suitable and reflective nursing care plan according to patient medical needs and doctors expectation, and other variables to be measure.

other themes can be assessed by the statistical reports from patient services quality department through knowledge of the complains raised by patients declaring lack in nursing services, also the positive reports from patients due to rate the services of nursing team meeting his expectations and needs, also measure for responsibility is in the reports of nursing medical error reporting and patient unexpected negative outcomes.

By making that quality nursing care within the current health care system, the mechanisms used for monitoring and evaluating care are under scrutiny. The demand for accountability for its services likewise increases. Individuals within the profession should assume responsibility for their professional actions for their care. Quality program help to increase the quality of nursing care and professional development.

These measuring reports give a background about the quality of nursing care and detect the negative results where the management has to resolve it either by replacement of staff, training and retraining staff or investing in health care quality programs to raise staff awareness about patient care.

Answer to Question 2

Qualitative indicators are the indicators of change and outcomes that indicates whether our work is leading to the changes in people's lives, rights and power. Also can be described as people's judgments and perceptions about a certain subject

In our hospital there is a number of quality indicators applied to measure the quality of performance of the services that provided by the hospital which mainly are quantitative measurements, but in case of qualitative measurements we will include the main two qualitative indicators patient satisfaction indicator and Healthcare Providers satisfaction. Which are important in development and progress of quality of care. Patient satisfaction is a qualitative measure but it is based on quantitative and qualitative variables which covers many hospital services, described as:

A-Tangibles assessment for, hospital facilities environment cleanliness, quality of the patient's food, waiting area arrangements, parking area for patients and special need, hospital security, doctors and nurses patience in hearing patient details.

B-Reliability assessment for: Doctors efficiency in assessment and treatment, the treatment effectiveness, test procedure.

C-Responsiveness assessment for: doctors and nurses response for patients requests, sufficient on-call doctors availability during night, convenience and quickness medical care process, emergency cases handled by the staff.

D-Assurance assessment through: Confidence given by the doctors, Confidence given by all staff, confidentiality between doctor and patient.

E- Empathy assessment by: waiting time for any health service time process in our facility, visitors time duration, care given to the patient families' requests for their patient.

Regarding Healthcare Providers satisfaction assessment through: employee growth factors, promotion and incentive procedures, salary applied to each position category, acceptance of procedure that control the communication chains between the heads and other staff, responsiveness and effectiveness to the staff complains of feedback and solutions.

Collection and analyzing the data: through patient satisfaction survey and assessment of patient perspective items. In addition, the quantitative data that helps in answering the quality measures collected from department's secretary files such statistics reports for each department and apply numerical and categorical analysis for different indicators depending on the nature of that value by percentages. Also, analyze and control by applying control charts that show our progress in service. Overall results show that performance efficiency to defined control limits and deviation from central line.

Impact of measures on patient care:

Reports and data collected for qualitative measures used to address and assess the deficiencies and strengths in our current practices. These analyzed results are indicator to gauge improvement according to the quality performance needs. It helps to align health service with the updated patient services. In this way we are regularly monitoring and maintaining our services continuously.

Family Medicine centers waiting time Example:

An example for that we applied some restrictions and arrangement through departmental policies and procedures about allowed waiting time in family medicine centers to reduce the treatment timing frame. We have suffered from long waiting time according to the analysis reports and results after applying the new improvement plan showed significant change in the waiting time, which was reflected in the patient satisfaction surveys as there was increase in percentage satisfaction in family medicine centers results.

Staff Satisfaction Example:

The issue with low staff satisfaction with hospital services. After performed root cause analysis we found that staff less motivated due to slow promotion process, not acknowledging the effective team members. Then the human resources department created criteria for new staff promotion and how to acknowledge highly effective staff. On this basis we started appointing heads and supervisors from existing teams and encouraged staff to participate more actively. We found through the statistics after one year that the satisfaction rate of the employee has increased significantly.

Factors affecting quality measure:

The parameters measurements listed in patient satisfaction indicators and Healthcare provider's satisfaction are the basic of the improvement care and assessing practices which is reflecting a satisfaction in the management level on the way the hospital is providing the care. Quality is subject to improve according to the recent modifications of practices in the healthcare services to stay competitive and reliable in care process.

Control of measure:

Controlled parameters can influence by changing practices and investing in highly expert staff through applying effectively. These include hospitality services, quality of equipment, food services, raising awareness and competency through international accreditations and applying new methods for hiring and promoting staff.

In our hospital we used to deal with the negative factors that affects the quality output, some issues like new governmental laws and logistic which was reflected on the employee benefits about the annual increase in basic salaries and housing allowances. Another factors affected the patient satisfaction care was the reduce of number of patients seen in family medicine centers after applying the new health information system for clinical care which arrange patient appointment and scheduled visits, that affect and increase the clinics and staff to fulfill the patient needs of the care services.

Answer to Question 3

Risk management for healthcare entities defined as an organized effort to identify, assess the risk to patients, visitors, staff and organizational assets. Through applying risk management, healthcare organizations safeguard patient safety, organization's assets, market share, accreditation, reimbursement levels, brand value, and community standing.

The element of risk management plan in healthcare practice are:

1-The purpose of risk management plan: aiming to define how risks associated with your targeted specific health service. It has to outline the performed and monitored planned activities throughout the lifecycle of the project and provides output templates and results for recording and prioritizing risks.

2-Identifying the risk: in the health care services and environment, this identification process through healthcare professionals and employees has various resources which can formulate the anticipated risk throughout the regular assessment reports by accreditation committees, executive committees, facility management and safety committee, incident reporting system and sentinel events.

3-Analyzing the risk: developing an understanding of the identified risks through calculating the level of risk ($\text{Risk score} = \text{Likelihood} \times \text{Severity of impact}$), underlying the root causes of adverse occurrences by applying brain storming with a team and addressing the existing control measures to minimize risk through applying effective tools and measures such as: Policies, procedures, code teams, Trainings and preventative maintenance controls.

4-Evaluation of Risks: used for prioritizing the risk according the results of risk score to apply the suitable plan for treating that risk.

5-Risk Treatment or Reduction: should be consistent with the defined internal, external and risk management contexts at the same time considering the objectives and goals of the services.

Treatment passes through phases:

A-Controlling the Risk: when potential risk is addressed is to apply redesigned systems and process, controlling the risks can be done through reducing the likelihood occurrence by preventative maintenance, audit and compliance programs, policies and procedures, training of staff, quality assurance programs or reducing the severity of impact through contingency planning, disaster recovery plans, emergency procedures, staff training, etc.

B-Avoiding the Risk: eliminate the cause of the threat.

C-Transferring the Risk: by making another party responsible for the risk such as, buy insurance, outsourcing.

D-Accepting the Risk: No action will be taken. For the risk

The integral part of the risk management cycle is to monitor and review the whole process of the risk management plan through utilizing source of information such as: Incident reporting, satisfaction survey, clinical audit indicators.

Address elements to the minimization of financial loss.

A proper and well developed healthcare risk management plan reduce patient health risks, financial and liability risks if the plan implemented and monitored within the frame time adjusted for that.

There are elements to minimize financial loss include, increasing of healthcare staff awareness about decreasing malpractice crises and patient unnecessary required prescriptions and clinical practices, reducing the number of falls and using skin protocols to prevent skin ulcers to control facility resources result in better care and safety measures which leads to reduce insurance costs and saving significant amount of capital lead to improved care and patient safety.

Develop a program to reduce the incidence of preventable accidents and injuries.

People tend to make errors, but these should not result in injuries. This is why safety should be emphasized in planning of any human environment. Development of a program leads to Zero incidence is important in an occupational safety and health management system. This program is

identify the management and healthcare roles and the hazards measures and tools of controlling them, there are six titles for this, which are:

1- Management Commitment:

Used to avail the necessary resources to form a safety committee from management and elected employees, which is responsible to develop a system for identifying and correcting hazards, planning for emergencies, provides training for employees and supervisors, and establish an organization safety policies.

Basic safety policy for healthcare facility and all employees are required to comply with the institution safety rules, supervisors are responsible for their direct employee's safety in terms of checking the workplace for unsafe conditions, and taking necessary actions to eliminate any hazards.

2- Safety and Health Responsibilities:

It is described among three levels of categories:

A-Managers Responsibility:

Insure that sufficient employee time, supervisor support, and funds for safety equipment, training for the safety program. Evaluate supervisors for carrying out their responsibilities. Insure that incidents are investigated and corrective action taken to prevent the hazardous conditions and behaviors from happening again. Insure that a record of injuries and accidents is maintained and posted as described in the program. And Report unsafe practices or to the supervisor where the hazard was observed.

B-Supervisors Responsibility:

Insure that employee has received orientation and essential safety trainings before starting activities in the work related equipment and systems. Insure that each employee receives required personal protective equipment (PPE) before starting work on a project requiring use it.

Do a regular check of the work area to correct any detected hazards. And talk to management about changes to work practices or equipment to improve employee safety.

C- Employees Responsibility:

Compliance with safety rules. Reporting to your supervisor any incident, injuries and any unsafe conditions or actions. Make suggestions to your supervisor, safety committee about the needed changes to improve employee safety.

3- Employee (Healthcare Providers) Participation

Through representing their departments in the safety committee, and responsible for in addition safety committee tasks, A monthly self-inspection of the area, Communicating with the employees on safety issues and encouraging safe work practices among co-workers

Attending employees safety meetings aimed to identify safety problems, develop solutions, review incidents reports, provide training and evaluate the effectiveness of the safety program.

4- Hazard Recognition:

A- Record Keeping and Review: Employees should report any work related illness or injury to their immediate supervisor by use an Employee's Injury/Illness Report Form.

B- Incident Investigation: will be conducted by the immediate supervisor of the injured person, an employee representative of the safety committee, and any other persons whose expertise would help the investigation.

C-Safety inspection Procedures:

Used to identify hazardous conditions and practices which are result in injury or illness, due to that management and the safety committee will check the workplace for hazards on annual, periodic and monthly basis.

5- Hazard Prevention and Control:

Basic safety rules used to control for safety from falls and medical errors and malpractice while performing clinical and non-clinical work includes:

- Never do anything that is unsafe to get the job done. Report unsafe jobs to your supervisor or safety committee representative.
- Use the personal protective equipment whenever it is required.
- Obey safety warning signs.
- prohibited working under the influence of alcohol or illegal drugs or using them at work.
- Smoking is only permitted outside the building in smoking area.
- Clean up spills immediately. Good housekeeping helps prevent injuries.

Disciplinary Policy: used to provide appropriate consequences for failure to follow safety rules. It is designed to bring the employee's attention to the unacceptable behavior to in a way that the employee will be motivated to make corrections.

Equipment Maintenance: for departments having machinery and equipment that must be inspected or serviced. A checklist record to document the maintenance items will be maintained on file for the life of the equipment.

6- Emergency Planning:

An evacuation map for the building is posted in each department, In case of fire. It shows the exits locations, fire extinguishers, first aid kits, and assembly points outside.

Include a description of the interaction between quality and risk management. Which include a description of a process improvement goal or a quality improvement plan.

Quality Risk Management is the set of leadership, culture, business process and technology. An organizations capabilities establishes to create an approach for identifying, quantifying product, operational, and supply chain risks that can impact quality.

How Risk Management and Quality perform in detecting safety issues:

Incident reporting systems is the early warning systems for risk managers for earlier identification of potential claims. Also, quality management specialists are reviewing medical records daily and overseeing a compensable events or other risk issues that may not reported. If the quality managers and risk management remain aware of the importance of sharing information, it is less likely that the important patient safety issues will be overlooked and left unaddressed.

Risk management and quality management effective interactive collaboration by developing a procedure for responding to adverse events. This procedure should set the responsibilities for each department in a way that minimizes redundancy with availability of exchange of important information.

Sample of hospital response plan describing how risk management and quality interacts in a healthcare facility mainly hospitals:

- 1- Upon identification of a defined adverse event, staff will notify risk management
- 2- Risk management will secure the medical record, documentation, supplies, packaging, operating manuals, etc., associated with the event. Immediate provided advice to practitioners as needed.
- 3- The risk manager inform the quality manager of the event as soon as possible to start both coordinating the investigation process. If it appears the incident meets reporting criteria defined the organization:

- Risk management notifies an executive organization leader.
- An incident report is completed and forwarded to risk management through concerned staff prior to end of the shift.
- The administrator-on-call, risk manager and the attending physician coordinate communication with the patient and family regarding the incident.
- Risk management, quality management, chief of designee, involved practitioners and the departments begin an investigation of the incident within 24 hours of notification of the incident.
- Quality management creates a detailed chart review with a specified timeline.
- Quality management assigns a peer reviewer to examine the medical record. Then both risk management and quality management discuss the findings with the peer reviewer. If the findings meet the criteria for reporting an adverse event, the risk manager contacts the involved physician or practitioners and departments.
- A review team comprising the CEO designee, chief of staff, section chief, medical officer chief, nurse executive, risk management, quality management, involved physician and department meets to review the incident .If the incident is a sentinel event, the CEO designee immediately notifies the board of directors.
- A Root Cause Analysis (RCA) is conducted with regulatory guidelines.
- The involved staff and practitioner have the opportunity to participate in the RCA. The quality management committee reviews the conducted RCA and completed peer reviews.
- The RCA is forwarded to the performance improvement committee, medical executive committee and board quality management.
- Corrective actions and risk-reduction strategies are implemented and monitored with reports for ongoing effectiveness to the appropriate quality management committees.

- Quality management, and risk management, ensures that appropriate interventions are taken to prevent recurrence of the event.

- The appropriate department director keeps risk management informed about corrective actions taken.

4- All meetings for review purposes are conducted and protected through quality management and peer review process and risk management.

5- Once the risk manager has determined that the incident is reportable, notify all persons identified on the report.

6- The risk manager refers all occurrences to the appropriate quality management committee.

An effective collaborative model begins with communication between the organization's risk manager and quality manager. By initiating a goal that is focus on patient safety focused, a risk and quality management partnership contribute to the overall quality of healthcare and personal satisfaction in our professional lives.

References

-Currentnursing.com. 2020. Total Quality Management In Nursing Care. [online] Available at: <http://currentnursing.com/nursing_management/total_quality_management_health_care.html> [Accessed 13 May 2020].

-Mnestudies.com. (2019). What are Indicators And Types of Indicators? | Monitoring and Evaluation Studies. [online] Available at: <http://www.mnestudies.com/monitoring/what-indicators-and-types-indicators> [Accessed 14 May 2020].

-Investopedia. (2019). The Importance of Healthcare Risk Management. [online] Available at: <https://www.investopedia.com/articles/personal-finance/072315/importance-healthcare-risk-management.asp> [Accessed 14 May 2020].

-NEJM Catalyst. (2019). What is Risk Management in Healthcare? – NEJM Catalyst. [online] Available at: <https://catalyst.nejm.org/what-is-risk-management-in-healthcare/> [Accessed 15 May 2020].

-World Health Organization. (2019). What is Quality of Care and why is it important? [online] Available at: https://www.who.int/maternal_child_adolescent/topics/quality-of-care/definition/en/ [Accessed 15 May 2020].

-Alam, A. (2019). Steps in the Process of Risk Management in Healthcare. [online] Elynsgroup.com. Available at: <https://www.elynsgroup.com/journal/article/steps-in-the-process-of-risk-management-in-healthcare> [Accessed 15 May 2020].

-Emeraldinsight.com. (2019). The PATH project in eight European countries: an evaluation | International Journal of Health Care Quality Assurance | Vol 26, No 8. [online] Available at: <https://www.emeraldinsight.com/doi/pdfplus/10.1108/IJHCQA-11-2011-0065> [Accessed 15 May 2020].

-Oshwiki.eu. (2019). Zero accident vision - OSHWiki. [online] Available at: https://oshwiki.eu/wiki/Zero_accident_vision [Accessed 16 May 2020].

-Ashrm.org. (2019). [online] Available at:

http://www.ashrm.org/pubs/files/white_papers/Monograph.07RiskQuality.pdf [Accessed 13 May 2020].

-Burhans, L. and Alligood, M. (2010). Quality nursing care in the words of nurses. *Journal of Advanced Nursing*, 66(8), pp.1689-1697.

-Littlefield, M. (2019). Quality Risk Management | A New Perspective. [online]

Blog.insresearch.com. Available at: <https://blog.insresearch.com/bid/126119/quality-risk-management-a-new-perspective> [Accessed 15 May 2020].