

Assessment 1 Instructions: Adverse Event or Near-Miss Analysis

Prepare an analysis (5-7 pages) of an adverse event or a near miss from your professional nursing experience and outline a QI initiative that would address it.

Introduction

Health care organizations strive to create a culture of safety. Despite technological advances, quality care initiatives, oversight, ongoing education and training, legislation, and regulations, medical errors continue to be made. Some are small and easily remedied with the patient unaware of the infraction. Others can be catastrophic and irreversible, altering the lives of patients and their caregivers and unleashing massive reforms and costly litigation. Many errors are attributable to ineffective interprofessional communication.

Overview

The goal of this assessment is to allow you to focus on a specific event in a health care setting that impacts patient safety and related organizational vulnerabilities and to propose a QI initiative to prevent future incidents. It will give you the chance to develop your analytical skills in the problem-solving contexts you likely find yourself in as a health care professional.

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Historically, medical errors were reported and analyzed in hindsight. Today, QI initiatives attempt to be proactive, which contributes to the amount of attention paid to adverse events and near misses. Backed up by new technologies and reporting metrics, adverse events and near misses can provide insight into potential ways to improve care delivery and ensure patient safety.

For clarification, the National Quality Forum (n.d.) defines the following:

- Adverse event: An event that results in unintended harm to the patient by an act of commission or omission rather than by the underlying disease or condition of the patient.
- Near miss: An event or a situation that did not produce patient harm, but only because of intervening factors, such as patient health or timely intervention.

Instructions

Prepare a comprehensive analysis of an adverse event or a near miss from your professional nursing experience that you or a peer experienced. Provide an analysis of the impact of the same type of adverse event or near miss in other facilities. How was it managed, who was involved, and how was it resolved? Be sure to:

- Analyze the implications of the adverse event or near miss for all stakeholders.
- Analyze the sequence of events, missed steps, or protocol deviations related to the adverse event or near miss using a root cause analysis.
- Evaluate QI actions or technologies related to the event that are required to reduce risk and increase patient safety.
 - Evaluate how other institutions integrated solutions to prevent these types of events.
 - Incorporate relevant metrics of the adverse event or near miss to support need for improvement.
- Outline a QI initiative to prevent a future adverse event or near miss.
- Ensure your analysis conveys purpose, in an appropriate tone and style, incorporating supporting evidence and adhering to organizational, professional, and scholarly writing standards.

Be sure your analysis addresses all of the above points. You may also want to read the Adverse Event or Near Miss Analysis Scoring Guide to better understand the performance levels that relate to each grading criterion. Additionally, be sure to review the [Guiding Questions: Adverse Event or Near Miss Analysis \[DOCX\]](#) document for additional clarification about things to consider when creating your assessment.

Additional Requirements

Your assessment should also meet the following requirements:

- **Length of submission:** A minimum of five but no more than seven double-spaced, typed pages, not including the title page or References section.
- **Number of references:** Cite a minimum of three sources of scholarly or professional evidence that support your evaluation, recommendations, and plans. Current source material is defined as no older than five years unless it is a seminal work. Review the [Nursing Master's Program \(MSN\) Library Guide](#) for guidance.
- **APA formatting:** Resources and citations are formatted according to current APA style. Review the [Evidence and APA](#) section of the Writing Center for guidance.

Competencies Measured

By successfully completing this assessment, you will demonstrate your proficiency in the following course competencies and scoring guide criteria:

- Competency 1: Plan quality improvement initiatives in response to adverse events and near-miss analyses.
 - Analyze the implications of an adverse event or a near miss for all stakeholders.
 - Analyze the sequence of events, missed steps, or protocol deviations related to an adverse event or a near miss using a root cause analysis.
 - Outline a quality improvement initiative to prevent a future adverse event or near miss based on research and evidence-based practices.
- Competency 3: Evaluate quality improvement initiatives using sensitive and sound outcome measures.
 - Evaluate and identify quality improvement actions or technologies related to an event that are required to reduce risk and increase patient safety.
- Competency 5: Apply effective communication strategies to promote quality improvement of

interprofessional care.

- Convey purpose, in an appropriate tone and style, incorporating supporting evidence and adhering to organizational, professional, and scholarly writing standards.

Reference

National Quality Forum. (n.d.). *NQF patient safety terms and definitions*.
http://www.qualityforum.org/Topics/Safety_Definitions.aspx



SCORING GUIDE

Use the scoring guide to understand how your assessment will be evaluated.

[VIEW SCORING GUIDE](#) 