

Quality Assurance and Safety Culture in a Healthcare Organization

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ABSTRACT

Patient care and quality management have as one of their primary focuses ensuring the safety of their patients. The four principles of biomedical ethics presented by Beauchamp and Childress are one quality management paradigm that emphasizes the importance of the patient. The Institute of Medicine's six improvement goals capture the essence of excellent medical treatment. Care, money, and health are the three pillars upon which the Institute for Healthcare Improvement's Triple Aim rests. The present review was written with the aforementioned contexts in mind, with the intention of highlighting the system's initiatives to address various efforts of enhancing quality and patient safety. We provide a reflective overview of healthcare legislation, policy, and regulation with special attention paid to the ideas of informed consent and informed refusal. This analysis also details the steps taken and regulations enforced by the administration and management to provide care that is focused on the individual patient. Finally, we discuss model policies like the Delivery System Reform Incentive Payment Program, which incorporates quality management frameworks, the Hospital-Acquired Conditions Reduction Program, which promotes patient safety, and the Hospital Readmissions Reduction Program, which aims to reduce hospital readmissions.

Keywords: Quality management frameworks, IOM's six aims for improvement, IHI's Triple Aim, Patient safety, Patient centeredness, High-quality clinical care

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BACKGROUND

Many factors, including optimization of high-quality care, play a role in the logistics of patient care and healthcare administration. Accreditation from The Joint Commission (TJC), performance excellence from the Malcolm Baldrige National Quality Award (MBNQA), and nursing excellence from the Magnet Recognition Program all indicate a high standard of care [1–3]. When it comes to healthcare accreditation, TJC is the undisputed leader worldwide [4]. Quality performance in patient care and safety can be evaluated objectively by this non-profit organization [4]. The MBNQA is the highest presidential award in the country for quality and efficiency [5]. In order to recognize and reward companies all over the world whose nursing leadership has successfully aligned nursing strategic goals to improve patient outcomes, the Magnet Recognition Program was created [6]. The Institute of Medicine (IOM) additionally classifies areas of care delivery with its six targets for

enhancement, in addition to the aforementioned healthcare recognition [7]. The Triple Aim, developed by the IHI, aims to enhance the quality of care, the health of populations, and the efficiency of healthcare spending per person. Here, we provide a synopsis of how biomedical ethics, the Six Aims for Improvement, and the Triple Aim all come together to prioritize patient safety and better treatment. In this article, we'll go over the clinical and managerial responsibilities that come along with ensuring patient safety in both urgent and routine situations. The motivation behind this paper is to serve as an example of current policies that promote patient centeredness while still maintaining parameters that enhance treatment, maintain quality, and boost safety. Patient safety is of paramount importance to any healthcare provider because of its central role in providing effective medical care. Clinicians provide hands-on treatment to patients. But does that mean that elements like lawmakers, leadership, and managers are operating in isolation from patient safety?

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Because these organizations create and implement policies to maintain and improve patient safety in their respective towns, institutions, and departments, "no" is a very plausible answer to the question posed above. Micro-level leadership, management, and doctors are responsible for enforcing, adopting, and practicing macro-level healthcare policies developed and recommended by policymakers.

RESEARCH QUESTIONS AND OBJECTIVES

The principles of biomedical ethics established by Beauchamp and Childress, the six purposes for improvement, and the Triple Aim are just a few examples of the quality management frameworks established by the existing body of literature. Each of the aforementioned models takes into account patients' wants and needs while also supporting efforts to enhance healthcare delivery. However, in some cases, patients who appear while asleep or under the influence of alcohol are unable to express their wishes on treatment. First, given the aforementioned scenario, what are some options for physicians to take into account as safe harbors when dealing with such patients? The second inquiry is, "When a patient gives or withholds consent, what are the clinicians' options for how to proceed?" The third line of inquiry is a natural extension of the second; specifically, what part does the administration play in enforcing policies that aren't covered by existing legislation? There are three goals for this analysis. First, based on the ideas of informed consent and informed refusal, we hope to suggest solutions to the dos and don'ts that clinicians might implement in emergency and non-emergency situations. Second, we seek to describe how hospital administration might promote high-quality care for patients while also minimizing risks to their health. Finally, we examine model policies that have recently been implemented as part of systemic initiatives to maintain patient safety and promote measures in care delivery. These include the Delivery System Reform Incentive Payment program, the Quadruple Aim, the Hospital-Acquired Conditions Reduction Program, and the Hospital Readmissions Reduction Program.

LITERATURE REVIEW

Quality management frameworks preserving patient safety: an overview of three established frameworks Beauchamp and Childress's principles of biomedical ethics

Faculty in the fields of medicine and surgery have a crucial role in fostering a culture of safety in patient care. There are four biomedical ethical principles that are relevant here. These values include "self-determination," "non-harm," "benefit," and "justice." [9]. These four tenets, known as the "four pillars of medical ethics," are the cornerstone of ethical medical care. Ethical medical and surgical decision making takes into account other aspects of biomedical ethics that arise from the aforementioned four principles [10]. The following is a rundown of some of these supplementary features:[10].

Integrity, Completeness of Information, and Privacy: Full disclosure is providing accurate and comprehensive information about the patient's medical condition, whereas truthfulness means not manipulating the facts when giving them to the patient. Confidentiality, on the other hand, refers to the policy of keeping a patient's health status secret [10]. The term "autonomy" is used to describe the principle of giving the patient unrestricted discretion over all medical decisions. This concept is front and center in debatable areas like abortion and end-of-life care [10]. Beneficence refers to the practice of helping a patient while causing them as little harm as possible.

The Institute of medicine's six aims for improvement model

According to the AHRQ Patient Safety Network, "freedom from accidental or preventable injuries produced by medical care" is a more comprehensive definition of harm prevention [11]. In addition, the IOM presented six goals for healthcare enhancement to better serve patients' healthcare requirements while also protecting their safety. Here are the six objectives: [7]. Safe means that treatment won't harm patients instead of helping them. When patients observe measures being accepted and put into effect that promote a safe environment, patient safety can become a system-wide strategy [7]. Efficient means not wasting time, money, resources, or energy in any way. Defensive medicine, malpractice litigation, systemic complexity, and administrative fraud and abuse are all examples of healthcare waste. Potentially bolstering healthcare efficiency, cost-effective care [7]. Efficient: ensuring that all those who could benefit from a service receive that service. Evidence-based medicine means making medical decisions based on the best available scientific evidence [7]. Care that is patient-centered recognizes and addresses the unique goals, interests, and values of each individual patient. Care is patient-centered if and only if the patient has agency over their own treatment. This method of patient care is prospective in that it incorporates components of teamwork and communication [7]. prompt: minimizing patients' and doctors' exposure to unnecessary delays. Patient care quality can suffer across the board when patients have to wait and because of hazardous delays [7]. Care that is uniform in quality and does not discriminate on the basis of demographic characteristics such as race, socioeconomic background, gender, etc. is considered equitable [7]. In order to achieve the first of the IOM's six goals for improvement, healthcare providers must verify that their processes are safe. Second, for future effectiveness, patient care must be in sync with current research. Third, the patient's cultural background, food, and individual preferences are taken into account when providing care. The aforementioned idea is crucial to the hospice care given to the terminally ill. Delivering and receiving care in a timely fashion means minimizing patient wait times. Unanticipated delays in treatment have the potential to cause significant, collateral harm to patients. However, timely care

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delivery is crucial to ensuring patient wellbeing. As a fifth point, cutting down on inefficiencies and duplications has the potential to lessen demands on already stretched healthcare budgets. Finally, equitable care is treatment that is consistent regardless of factors such as socioeconomic status, race, or ethnicity, or income level [7].

The Institute of healthcare improvement's triple aim model

Care, cost, and health outcomes are all taken into account in the Triple Aim model developed by the Institute for Healthcare Improvement (IHI) [8]. The Triple Aim approach developed by the IHI entails the following three goals: [8]. One way to track how satisfied patients are with their care is through surveys like the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) [12, 13]. The National Practitioner Data Bank (NPDB) also helps in preventing healthcare fraud and abuse and encouraging high-quality medical care [14]. Reducing healthcare spending on an individual basis is possible through measures such as prescribing less expensive generic medications rather than more expensive brand-name drugs [8]. Promoting community wellness [8]. The Triple Aim is a conceptual framework developed by the IHI to explain a strategy with three interconnected goals. In order, we have bettering the health of populations, enhancing the quality of the care individuals receive, and minimizing the cost of healthcare per capita by cutting down on waste and variation. As a result of its broad applicability, the IHI's Triple Aim approach can be used to simplify administrative burdens associated with promoting and maintaining population health and wellness. Advances in medical technology that positively affect the patient experience of care fall under the first pillar of the Triple Aim, which focuses on improving the experience of care [8]. Implementing telemedicine and telehealth programs, for instance, contributes to the second component of the Triple Aim, decreasing per capita expenditures of care. When doctors can't be physically there, telemedicine bridges the gap with rapid, effective treatment [8]. One of the benefits of telemedicine is that it has the potential to expand patients' access to medical services. On the other side, it explains this to doctors and patients who may not be familiar with e-health. The third part of the Triple Aim, bettering the health of the population, is relevant to easing the attainment of the first two goals. Therefore, the IHI's Triple Aim model is a three-pointed framework, with the first two purposes being essential to the third aim, which is to improve population health [8].

DISCUSSION

The roles of clinical faculty and administration in patient safety: adoption and implementation of best practices in emergency and non-emergency cases

The federal Emergency Medical Treatment and Active Labor Act (EMTALA) mandates that all patients who present to an

emergency room be stabilized and treated, regardless of their insurance coverage or financial resources [15]. Patients have a right to treatment and medical professionals have a duty to offer it under EMTALA [15]. In this light, let's imagine an unconscious ER patient who is not comfortable with the idea of obtaining a blood transfusion. Was patient-centered care delivered in the preceding hypothetical if the treating practitioner, unaware of the unconscious patient's preferred culture, performed a blood transfusion to revive the patient? The provider's evaluation in the context of EMTALA is probably where to look for the solution. First and foremost, the evaluation is about the clinician's legal responsibility to treat all patients, especially in urgent situations. In non-emergency settings, where patients and doctors both have freedom of choice regarding who treats them, the aforementioned hypothetical scenario takes on an entirely different dynamic. The reason for this is due to the fact that a physician-patient contract is based on the nature of the doctor-patient bond [16]. Since the doctor has contractually agreed to treat the patient in exchange for payment, the relationship between them is governed by contract law [16]. Without a signed agreement between the doctor and patient, the doctor has no legal obligation to provide care [16]. The term "informed consent" refers to a step in the process of providing medical care in which the doctor gives the patient information about the treatment they will receive and discusses its potential risks and benefits with them [17]. As American judge Benjamin Cardozo stated in 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," this is the basis of the concept of informed consent [18]. The idea of "Informed Refusal" was developed to address the unique situation that arises when a patient does not give their consent for treatment in a non-emergency situation [19, 20]. The patient will list their end-of-life preferences in a living as an example of an informed refusal document [21]. In the aforementioned situation, the provider respects the patient's wishes about end-of-life care and/or refrains from treating the patient in accordance with the living will. Enforcing EMTALA and assisting physicians in becoming aware of informed consent and informed refusal procedures in organizations are the roles of leadership. Additionally, they make sure that healthcare professionals follow the aforementioned patient preference policies. Leadership has the authority to enact rules in medical situations when they do not already exist as laws, but they must be cautious to ensure that they do not go against public policy.

Macro-level healthcare programs focusing on patient safety: prototype policies

Delivery system reform incentive payment program: focusing on alignment with quality management frameworks

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The Delivery System Reform Incentive Payment (DSRIP) program is one example of a prototype law that applies the Triple Aim approach and all six goals for development. With several metrics and milestones in primary care, specialized care, chronic care, navigation and case management, disease prevention and wellness, and general categories, DSRIP has numerous healthcare projects that enhance health statuses [23, 24]. When embraced by healthcare institutions, these initiatives are systematically funded by the State Department of Health [22–26]. The DSRIP structure consists of four parts: (1) Infrastructure Development, (2) Program Innovation and Redesign, (3) Quality Improvement, and (4) Improvement in Population Health in states where its projects are implemented [22–26]. About 172 projects in eight cohorts—primary care, emergency care, chronic care, navigation/case management, disease prevention and wellness, behavioral health/substance abuse prevention, and general—were part of the Texas DSRIP program's southeastern county region in its third year of operation. [22, 23, 25] The IOM's six patient care goals—safe, effective, efficient, patient-centered, timely, and equitable—were simultaneously incorporated into each cohort's defined number of projects that involved completing patient care milestones and metrics [22–25]. DSRIP has been measured to increase population health by having all of its programs implemented in the adopted regions and counties [25]. Preventable hospitalization rate was one statistic used by the DSRIP program to gauge population health progress [24]. The dynamics and fundamental architecture of the DSRIP policy may have contributed to the decline in preventable hospitalization rates [23, 24]. These dynamics included interplaying healthcare externalities, systems for incentive payments, types of measurements for reporting outcomes in quality, and physician-administrator collaboration [24]. When examined using an interrupted time series approach, a statistically significant reduction in preventable hospitalization rates was seen in the accepted regions and counties [25]. The Texas DSRIP program was divided into two stages, 1.0 and 2.0. Comprehensive Diabetes Care: eye exam metric increased by 16% in DSRIP 2.0, and influenza immunization increased by 12% in the latter [27]. Researchers Revere et al. found that the metrics for catheter-associated urinary tract infections (CAUTI), surgical infections (SSI), and central line associated bloodstream infections (CLABSI) rates all improved in DSRIP 2.0 by 26%, 10%, and 9%, respectively [27].

Quadruple aim framework: focusing on the evolution of the triple aim

In 2008, the Triple Aim was developed, focusing on three objectives: care, cost, and health. In 2015, Sikka and colleagues created a fourth goal: enhancing the caregiving experience. The purpose of this was to recognize the significance of doctors, nurses, and all other personnel "finding joy and meaning in their work and thereby improving the experience of providing care." [28]. The sensation of joy and purpose in providing care is at the heart

of the fourth aim, making it synonymous with gaining accomplishment and significance in their efforts. The Quadruple Aim has extensive implications for theory and practice, taking into account inclusivity for all healthcare workforce members [28].

Hospital-Acquired conditions reduction program: focusing on patient safety

The CMS's ongoing effort to tie Medicare payments to healthcare quality in the inpatient hospital setting is supported by the Hospital-Acquired Conditions Reduction Program (HACRP), a Medicare pay-for-performance initiative [29]. Healthcare-associated infections (HAIs), which are measured by the National Healthcare Safety Network (NHSN) of the Centers for Disease Control and Prevention (CDC), are the following: [30] (1) Central Line Associated Blood Stream Infection (CLABSI), (2) Catheter Associated Urinary Tract Infection (CAUTI), (3) Surgical Site Infection (SSI) for colon and hysterectomy, (4) Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteremia, (5) Clostridium Difficile Infection (CDI). Additionally, eight Patient Safety Indicators (PSIs) included in the program comprise of: [31] (1) PSI 03 - Pressure Ulcer Rate, (2) PSI 06 - Iatrogenic Pneumothorax Rate (3) PSI 07 - Central Venous Catheter Related Bloodstream Infection Rate, (4) PSI 08 - Postoperative Hip Fracture Rate, (5) PSI 12 - Perioperative Pulmonary Embolism or Deep Vein Thrombosis Rate, (6) PSI 13 - Postoperative Sepsis Rate, (7) PSI 14 - Postoperative Wound Dehiscence Rate, (8) PSI 15 - Accidental Puncture or Laceration Rate.

Hospital readmissions reduction program: focusing on patient safety

A Medicare value-based buying scheme called the Hospital Readmissions Reduction scheme (HRRP) lowers compensation to hospitals that have too many readmissions. By associating payment with the caliber of hospital care, the initiative advances the national objective of bettering healthcare [32]. To decrease readmissions, which in turn increase patient safety, HRRP has a focus on the following issues: [32]. Those conditions are as follows: [32] (1) Acute Myocardial Infarction (AMI), (2) Chronic Obstructive Pulmonary Disease (COPD), (3) Heart Failure (HF), (4) Pneumonia (5) Coronary Artery Bypass Graft (CABG) surgery, and (6) Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty (THA/TKA) [32].

CONCLUSION

Through the prism of the aforementioned quality management frameworks, patient safety was to be examined in this review. We explicitly included examples of legislation and practices including EMTALA, informed consent, informed refusal, and living wills. While the EMTALA regulations apply in emergency situations, obtaining the patient's informed consent is still necessary in non-emergency situations. If the patient declines therapy, it would be best to

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record their informed decline. With a focus on the measures the system has actively taken to enhance patient safety and improve the quality-of-care delivery, we highlighted a few new prototype policies that are percolating up from national policymaking to institutional levels.

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