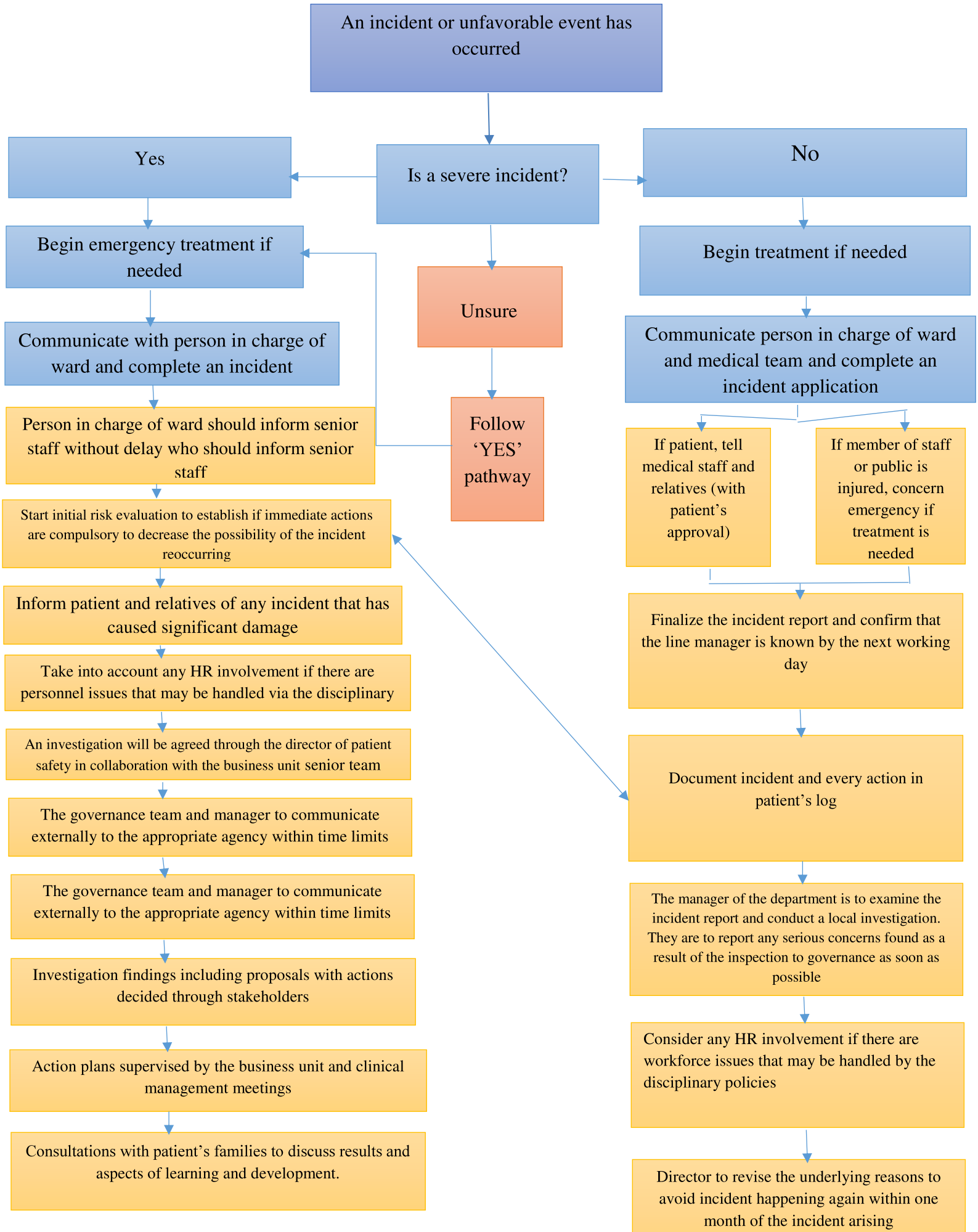
Workflow Analysis

Name

Institution Affiliation

Patient Safety Incident Reporting Flowchart



Assignment: Workflow Analysis - Creating a Flowchart

Introduction

Indeed, healthcare information technology has created room for significant clinical enhancements and process efficiencies. To achieve this, it is essential to tackle and overpower the different issues that result from irrelevant and inadequate work process designs. Flowcharts are an illustration of the workflow of hospital activities that assist in making many decisions. Process flow charts are important in demonstrating the phases that are involved in providing healthcare. It aids in establishing disparities, holdups, and areas of improvement.

In the Event of an Incident

Immediate action

The person that detects the incident must act promptly to safeguard the safety of the patients, staff, and other service users. This should be followed by informing the person in charge of that area of the incident that has occurred (Wagner et al., 2016). For sections that do not have a local manager (in car parks or corridors), the proper amenities, maintenance, and domestic crew must be notified if action should be taken. If there is a patient involved in the incident, the specifics of the incident should also be documented in the nursing and medical logs with proper scrutiny as needed.

Reporting an Incident

Incident reporting system

Every occurrence, even close calls, should be reported on the web-based incident reporting system. They must be conveyed as early as possible following the incident happening, or the incident being established (Michel et al., 2017). When an incident is determined after the event, the person that realized it must finish the incident statement.

Every relevant part of the incident report form must be filled together with the particulars of any witnesses to facilitate the interview process if an investigation is compulsory.

Impact of the Incident

The incident statement comprises questions that try to ascertain the actual effect (extent of loss or harm) of the incident. When communicating a patient safety incident, the real impact signifies the weight of the incident and will assist in updating the intensity of investigation needed.

Manager Action

The web-based reporting system updates appropriate managers and other vital personnel. Directors should log into the system and certify these aspects:

I. Check the facts of the incident and confirm that the risk evaluation and the actual impact scoring are relevant.
II. Instruct senior management if the incident is considered critical.
III. Respond to the person that presented the report and give support appropriately.
IV. Complete and review the incident report as early as possible, within a period of 30 days of the incident being communicated. This should include the measures enforced to thwart the incident from reoccurring and the main causes of the incident (Wagner et al., 2016).

Metrics to Measure the Soundness of the Workflow

Patient Experience

This is an effective method because the organization collaborates with other research centers to gauge the patients' opinions of their experience. A sample of patients is provided with questionnaires and surveys two weeks after they are discharged from the hospital. The nursing department analyses the relationships between the perception data that they receive

from the patients and the nurses' performance reviews (Murphy, 2012). This will aid in stimulating improvement in the areas that are concerned with the discharge process.

Nursing Quality Indicators

The organization would be assisted by external research centers that will provide them with annual and quarterly reports of process, outcome indicators, and structure to assess the delivery of health care at the unit level. This is a useful measure as the information provided will be re-examined quarterly/monthly by the nursing managers and submitted to the committee.

Infection Prevention and Control

About half of the patients that are admitted are immunocompromised because of treatment/therapy or core disease processes. This metric is effectual as it ensures that the potentially susceptible patients are safeguarded from harm. This is only possible through ensuring that averting hospital-acquired infections is the principal emphasis in the organization (Arries, 2017). The hospital would also require an outspoken surveillance program to establish the risks of infection control, a staff training initiative, and a vigorous risk mitigation program.

Clinical Documentation

Another useful metric that could be used in measuring the soundness of the workflow in the organization is documentation. Proper and timely documentation of medical concerns in the patient's health records is essential to providing quality health care. The organization's information management division monitors key quality metrics that are associated with patient care. This data is submitted to the committee that handles clinical quality and information management.

Recommendations

1. Encouraging the hospital management to utilize a fair approach to the evaluation of patient safety events.

2. Finding methods to institute a norm of reporting that assesses incidents and captures near misses to avert future incidents by establishing process improvement programs.

3. Instituting fast and simpler reporting systems to further regular reporting that does not undermine anyone's daily workload.

4. Assigning a patient safety leader in the hospital

5. Performing a yearly assessment of patient safety with personnel that elucidates on what a practitioner should do when an incident occurs.

6. Endorsing best practices via benchmarking and peer-review programs.

7. Assessing intake processes and prompt tentative responses to handle particular cases of potential incidents and execute process improvement strategies consequently.

8. Providing proper quantity and quality in hospital staff training for the staff to involve themselves safely and more efficiently in daily hospital procedures.

9. Identifying strategies for tackling behaviors that are detrimental to a culture of safety.

10. Having the hospital processes stop till an incident is fixed.

11. Updating the staff that different survey outcomes established intermissions as the primary problem reported for all aspects (Lennox-Chhugani, Horrigan, Stein, & Jain, 2015). Making the personnel aware of this can help them consider it in their daily workload.

12. Encouraging best practices for the management of high-risk hospital procedures and medication.

13. Involving patients in their care to help in improving their safety.

14. Creating a process for interaction with the patient and relatives in a modern model if there is a patient safety event.

15. Establishing a way of informing the patient about the safety considerations of accepting treatment (Hesselink, Berben, Beune, & Schoonhoven, 2016). This could assist in reducing unfeasible time expectations, thereby limiting the pressure on the practitioner to consider safety at the expense of time.

16. Engaging policymakers to visit the organization to give insight on hospital activities.

17. Sustaining the enhancement of health information exchange.

21. Promoting the awareness of human factors engineering and its implications for medication safety.

18. Upholding the understanding of human factors and the consequences on patient safety.

Summary

Future studies on the organizations' workflow should emphasize on appropriate methods to modify behavior and gain from the incidents that have happened. This modification should be centered on rigorous insight into the incident forms and the underlying causes at the unit level. Immediate and direct response to health care providers is very significant to ensure that they are consistently involved (Aguilar et al., 2013). A database containing information on the kinds of incidents and types of underlying causes could assist in establishing tendencies, document causal factors, and permit units to keep track of changes over time.

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