# Resources: Evidence-Based Practice

* PRINT
* Evidence-Based Practice
	+ Giomuso, C. B., Jones, L. M., Long, D., Chandler, T., Kresevic, D., Pulphus, D., & Williams, T. (2014). [A successful approach to implementing evidence-based practice](http://ezproxy.library.capella.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=ccm&AN=109799107&site=ehost-live&scope=site%3C/div%3E). *Med-Surg Matters, 23*(4), 4–9.
		- This article provides a baseline definition of *evidence-based practice* as well as examples of implementing EBP in practice.
	+ Spruce, L. (2015). [Back to basics: Implementing evidence-based practice](http://library.capella.edu/login?qurl=https%3A%2F%2Fsearch.proquest.com%2Fdocview%2F1639906860%3Faccountid%3D27965). *AORN Journal: The Official Voice of Perioperative Nursing*, *101*(1), 106–114.
		- This article provides a framework for identifying and appraising research, as well as implementing changes and practices based on research.
* Quality and Safety
	+ Ambutas, S., Lamb, K. V., & Quigley, P. (2017). [Fall reduction and injury prevention toolkit: Implementation on two medical-surgical units](http://library.capella.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=ccm&AN=123430220&site=ehost-live&scope=site). *Medsurg Nursing*, *26*(3), 175–179, 197.
		- The implementation of a safety improvement project is examined in this article.
	+ Institute for Healthcare Improvement. (n.d.). [*Why is reducing harm* – *not just error* – *important to patient safety?* [Video]](http://www.ihi.org/education/IHIOpenSchool/resources/Pages/Activities/Bates-Reducing-Harm-Important-To-Patient-Safety.aspx)*.* Retrieved from http://www.ihi.org/education/IHIOpenSchool/resources/Pages/Activities/Bates-Reducing-Harm-Important-To-Patient-Safety.aspx
		- Based on the premise that human error may be reduced but not avoided in every health care situation, this video focuses on the importance of harm reduction to patient safety.
	+ Joint Commission. (2018). [2018 national patient safety goals](https://www.jointcommission.org/standards_information/npsgs.aspx). Retrieved from https://www.jointcommission.org/standards\_information/npsgs.aspx
		- The patient safety resources on this Web page may be helpful as you develop the improvement plan section of your assessment.
	+ Mills, E. (2016). [The WakeWings journey: Creating a patient safety program](http://library.capella.edu/login?qurl=https%3A%2F%2Fsearch.proquest.com%2Fdocview%2F1790895560%3Faccountid%3D27965). *AORN Journal*, *103*(6), 636–639.
		- This article summarizes the creation of a safety program to reduce sentinel events.
	+ [U.S. Department of Health & Human Services](https://www.hhs.gov/). (n.d.). Retrieved from https://www.hhs.gov/
		- Explore numerous resources related to quality and safety on this website as you develop your assessment submission.

# Resources: Root-Cause Analysis

* PRINT
* Root-Cause Analysis
	+ Institute for Healthcare Improvement. (n.d.). [*Cause and effect diagram* [Video]](http://www.ihi.org/education/IHIOpenSchool/resources/Pages/AudioandVideo/Whiteboard16.aspx). Retrieved from http://www.ihi.org/education/IHIOpenSchool/resources/Pages/AudioandVideo/Whiteboard16.aspx
		- Cause and effect (or *fishbone*) diagrams are often used in root-cause analyses; this video shows how to create them.
	+ Institute for Healthcare Improvement. (n.d.). [Introduction to trigger tools for identifying adverse events](http://www.ihi.org/resources/Pages/Tools/IntrotoTriggerToolsforIdentifyingAEs.aspx). Retrieved from http://www.ihi.org/resources/Pages/Tools/IntrotoTriggerToolsforIdentifyingAEs.aspx
		- Tools to identify adverse events and determine their causes are provided on this resource page.
	+ Mellinger, E. (2014). [Action needed to prevent wrong-site surgery events](http://library.capella.edu/login?qurl=https%3A%2F%2Fsearch.proquest.com%2Fdocview%2F1519295794%3Faccountid%3D27965). *AORN Journal*, *99*(5), C5–C6.
		- This article examines the role nurses play in preventing and examining sentinel events.
	+ Minnesota Department of Health. (n.d.). [Root cause analysis toolkit](https://www.health.state.mn.us/facilities/patientsafety/adverseevents/toolkit/). Retrieved from https://www.health.state.mn.us/facilities/patientsafety/adverseevents/toolkit/
		- The Minnesota Department of Health offers an extensive collection of resources related to root-cause analysis.
	+ The Joint Commission. (n.d.). [Framework for conducting a root cause analysis and action plan](http://www.jointcommission.org/Framework_for_Conducting_a_Root_Cause_Analysis_and_Action_Plan/). Retrieved from http://www.jointcommission.org/Framework\_for\_Conducting\_a\_Root\_Cause\_Analysis\_and\_Action\_Plan/
		- With resources for conducting a root-cause analysis and creating an action plan to address the results, this Web page will help you understand the steps and processes of RCAs and improvement plans for this assessment.

# Resources: Sentinel Events

* PRINT
* Sentinel Events
	+ The Joint Commission. (2017). [Sentinel event policy and procedures](https://jointcommission.org/sentinel_event_policy_and_procedures). Retrieved from https://jointcommission.org/sentinel\_event\_policy\_and\_procedures
		- This Web page provides definitions, policies, and procedures related to sentinel events that may help you complete your assessment.
	+ The Joint Commission. (2017). [The essential role of leadership in developing a safety culture [PDF]](https://www.jointcommission.org/sea_issue_57/). *Sentinel Event Alert*, 57, 1–8. Retrieved from https://www.jointcommission.org/sea\_issue\_57/
		- According to The Joint Commission, "Competent and thoughtful leaders…understand that systemic flaws exist and each step in a care process has the potential for failure simply because humans make mistakes." This issue of *Sentinel Event Alert* discusses ways that effective leaders foster the development of a safety culture.

# Resources: Safety and Sentinel Event Case Studies

* PRINT
* Safety and Sentinel Event Case Studies
	+ Institute for Healthcare Improvement. (n.d.). [One dose, fifty pills (AHRQ)](http://www.ihi.org/education/IHIOpenSchool/resources/Pages/Activities/AHRQCaseStudyOneDoseFiftyPills.aspx).;Retrieved from http://www.ihi.org/education/IHIOpenSchool/resources/Pages/Activities/AHRQCaseStudyOneDoseFiftyPills.aspx
	+ Institute for Healthcare Improvement. (n.d.). [*Josie King - What happened to Josie?* [Video]](http://www.ihi.org/education/IHIOpenSchool/resources/Pages/Activities/WhatHappenedtoJosieKing.aspx). Retrieved from http://www.ihi.org/education/IHIOpenSchool/resources/Pages/Activities/WhatHappenedtoJosieKing.aspx

# Activity: Quality and Safety Improvement Plan Knowledge Base

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### [QUALITY AND SAFETY IMPROVEMENT PLAN KNOWLEDGE BASE](https://courserooma.capella.edu/webapps/blackboard/execute/blti/launchLink?course_id=_267495_1&content_id=_9122584_1)

* Click the linked title above, Quality and Safety Improvement Plan Knowledge Base, to complete this formative activity, which will help you check and build your knowledge of key concepts and terms related to quality and safety improvement. These terms and concepts will be useful as you prepare your Root Cause Analysis and Improvement Plan. This is for your own practice and self-assessment.

# Quality and Safety Improvement Plan Knowledge Base



For each term, select the explanation that best fits.

**Question 1 of 12**

Root Cause Analysis

*Choose one answer.*

a) A healthcare structure, product, service, process, or outcome that does not meet its customers' expectations and, therefore, could be improved.

b) The results of care, treatment, and services in terms of the patient's expectations, needs, and quality of life, which may be positive and appropriate or negative and diminishing.

c) An unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. The phrase "or risk thereof" includes any process variation for which a recurrence would carry a significant chance of serious adverse outcome.

d) A method of problem solving used for identifying the root causes of faults or problems.

**Question 2 of 12**

Evidence-Based Practice

*Choose one answer.*

a) The relationship between the outcomes (results of care) and the resources used to deliver care.

b) Integrates three basic principles: (1) the best available research evidence bearing on whether and why a treatment works, (2) clinical expertise (clinical judgment and experience) to rapidly identify each patient's unique health state and diagnosis, their individual risks and benefits of potential interventions, and (3) client preferences and values.

c) The systematic comparison of the products, services, and outcomes of one organization's outcomes with regional or national standards.

d) Sets of patient care characteristics that The Joint Commission (TJC) and Centers for Medicare & Medicaid Services (CMS) have determined to reflect the quality of care an organization can provide for important diagnoses.

**Question 3 of 12**

Sentinel Event

*Choose one answer.*

a) Tools that facilitate the collection, display, and analysis of data and information and that help team members stay focused, including cause-and-effect diagrams, graphic presentations, and others.

b) An unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. The phrase "or risk thereof" includes any process variation for which a recurrence would carry a significant chance of serious adverse outcome.

c) A method of problem solving used for identifying the root causes of faults or problems.

d) The interrelated activities of healthcare organizations-including governance, managerial support, and clinical services-that affect patient outcomes across departments and disciplines within an integrated environment.

**Question 4 of 12**

Core Measures

*Choose one answer.*

a) Sets of patient care characteristics that The Joint Commission (TJC) and Centers for Medicare & Medicaid Services (CMS) have determined to reflect the quality of care an organization can provide for important diagnoses.

b) The systematic comparison of the products, services, and outcomes of one organization's outcomes with regional or national standards.

c) Tools that facilitate the collection, display, and analysis of data and information and that help team members stay focused, including cause-and-effect diagrams, graphic presentations, and others.

d) The relationship between the outcomes (results of care) and the resources used to deliver care.

**Question 5 of 12**

Cost

*Choose one answer.*

a) The amount of financial resources consumed in the provision of healthcare services.

b) A healthcare structure, product, service, process, or outcome that does not meet its customers' expectations and, therefore, could be improved.

c) The results of care, treatment, and services in terms of the patient's expectations, needs, and quality of life, which may be positive and appropriate or negative and diminishing.

d) The relationship between the outcomes (results of care) and the resources used to deliver care.

**Question 6 of 12**

Effectiveness

*Choose one answer.*

a) The interrelated activities of healthcare organizations-including governance, managerial support, and clinical services-that affect patient outcomes across departments and disciplines within an integrated environment.

b) The relationship between the outcomes (results of care) and the resources used to deliver care

c) The degree to which care is provided in the correct manner, given the current state of knowledge, to achieve the desired or projected outcome(s) for the individual.

d) Integrates three basic principles: (1) the best available research evidence bearing on whether and why a treatment works, (2) clinical expertise (clinical judgment and experience) to rapidly identify each patient's unique health state and diagnosis, their individual risks and benefits of potential interventions, and (3) client preferences and values.

**Question 7 of 12**

Efficiency

*Choose one answer.*

a) The relationship between the outcomes (results of care) and the resources used to deliver care.

b) The results of care, treatment, and services in terms of the patient's expectations, needs, and quality of life, which may be positive and appropriate or negative and diminishing.

c) The degree to which care is provided in the correct manner, given the current state of knowledge, to achieve the desired or projected outcome(s) for the individual.

d) The amount of financial resources consumed in the provision of healthcare services.

**Question 8 of 12**

Process

*Choose one answer.*

a) The interrelated activities of healthcare organizations-including governance, managerial support, and clinical services-that affect patient outcomes across departments and disciplines within an integrated environment.

b) A healthcare structure, product, service, process, or outcome that does not meet its customers' expectations and, therefore, could be improved

c) The systematic comparison of the products, services, and outcomes of one organization's outcomes with regional or national standards.

d) Sets of patient care characteristics that The Joint Commission (TJC) and Centers for Medicare & Medicaid Services (CMS) have determined to reflect the quality of care an organization can provide for important diagnoses.

**Question 9 of 12**

Opportunity for Improvement

*Choose one answer.*

a) Tools that facilitate the collection, display, and analysis of data and information and that help team members stay focused, including cause-and-effect diagrams, graphic presentations, and others.

b) A healthcare structure, product, service, process, or outcome that does not meet its customers' expectations and, therefore, could be improved.

c) Members of the healthcare organization who have formed a functional or cross-functional group to examine a performance issue and make recommendations with respect to its improvement.

d) The results of care, treatment, and services in terms of the patient's expectations, needs, and quality of life, which may be positive and appropriate or negative and diminishing.

**Question 10 of 12**

Performance Improvement Team

*Choose one answer.*

a) Tools that facilitate the collection, display, and analysis of data and information and that help team members stay focused, including cause-and-effect diagrams, graphic presentations, and others.

b) Sets of patient care characteristics that The Joint Commission (TJC) and Centers for Medicare & Medicaid Services (CMS) have determined to reflect the quality of care an organization can provide for important diagnoses.

c) A healthcare structure, product, service, process, or outcome that does not meet its customers' expectations and, therefore, could be improved.

d) Members of the healthcare organization who have formed a functional or cross-functional group to examine a performance issue and make recommendations with respect to its improvement.

**Question 11 of 12**

QI Toolbox Techniques

*Choose one answer.*

a) Tools that facilitate the collection, display, and analysis of data and information and that help team members stay focused, including cause-and-effect diagrams, graphic presentations, and others.

b) The interrelated activities of healthcare organizations-including governance, managerial support, and clinical services-that affect patient outcomes across departments and disciplines within an integrated environment.

c) Sets of patient care characteristics that The Joint Commission (TJC) and Centers for Medicare & Medicaid Services (CMS) have determined to reflect the quality of care an organization can provide for important diagnoses.

d) The systematic comparison of the products, services, and outcomes of one organization's outcomes with regional or national standards.

**Question 12 of 12**

Benchmarking

*Choose one answer.*

a) The systematic comparison of the products, services, and outcomes of one organization's outcomes with regional or national standards.

b) The degree to which care is provided in the correct manner, given the current state of knowledge, to achieve the desired or projected outcome(s) for the individual.

c) The results of care, treatment, and services in terms of the patient's expectations, needs, and quality of life, which may be positive and appropriate or negative and diminishing.

d) Sets of patient care characteristics that The Joint Commission (TJC) and Centers for Medicare & Medicaid Services (CMS) have determined to reflect the quality of care an organization can provide for important diagnoses.

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