# Resources: Collaboration and Leadership

* PRINT
* Collaboration and Leadership
	+ Falls, E., & Hensel, D. (2012). [Characteristics that perinatal nurse managers desire in new nurse hires](http://library.capella.edu/login?qurl=https%3A%2F%2Fsearch.proquest.com%2Fdocview%2F1009617855%3Faccountid%3D27965). *The Journal of Continuing Education in Nursing*, *43*(4), 182–187.
		- This article may be helpful with identifying ways to coordinate and lead quality and safety measures related to the assessment.
	+ McInnes, S., Peters, K., Bonney, A., & Halcomb, E. (2015). [An integrative review of facilitators and barriers influencing collaboration and teamwork between general practitioners and nurses working in general practice](https://onlinelibrary-wiley-com.library.capella.edu/doi/10.1111/jan.12647). *Journal of Advanced Nursing*, *71*(9), 1973–1985.
		- This literature review may be a useful source for evidence and best practices to integrate into your assessment.
	+ Strech, S., & Wyatt, D. A. (2013). [Partnering to lead change: Nurses' role in the redesign of health care](http://search.proquest.com.library.capella.edu/docview/1428042963?accountid=27965). *AORN Journal: The Official Voice of Perioperative Nursing, 98*(3), 260–266.
		- This article examines competencies that may help nurses collaborate more effectively to improve patient outcomes.

# Resources: Quality Improvement Initiatives

* PRINT
* Quality Improvement Initiatives
	+ Allison, J. (2016). ;[Ideas and approaches for quality-assessment and performance-improvement projects in ambulatory surgery centers](https://search-proquest-com.library.capella.edu/docview/1784425493?https://library.capella.edu/login?url=accountid=27965&pq-origsite=summon). ;*AORN Journal, 103*(5), 483–488.
		- This article focuses on approaches and indicators customary to the services and operations of an ambulatory surgery center, going beyond reviewing data from routine outcome measures and explaining the effect these ideas can have on improving quality of care.
	+ Coles, E., Wells, M., Maxwell, M., Harris, F. M., Anderson, J., Gray, N. M., . . . MacGillivray, S. (2017). ;[The influence of contextual factors on healthcare quality improvement initiatives: What works, for whom and in what setting? Protocol for a realist review](https://systematicreviewsjournal.biomedcentral.com/articles/10.1186/s13643-017-0566-8). ;*Systematic Reviews,* ;6, 168–178. Retrieved from https://systematicreviewsjournal.biomedcentral.com/articles/10.1186/s13643-017-0566-8
		- This article examines ways in which the context of a quality improvement initiative plays a role in its success or failure and should help you consider the context of your proposed quality improvement initiative.
	+ Institute for Healthcare Improvement. (n.d.). ;[*Reliability series part 1: What is reliability?* ;[Video]](http://www.ihi.org/education/IHIOpenSchool/resources/Pages/Activities/FrankReliability1.aspx). ;Retrieved from http://www.ihi.org/education/IHIOpenSchool/resources/Pages/Activities/FrankReliability1.aspx
		- This video discusses the relationship between reliability and quality in health care.
	+ Lawton, R., Carruthers, S., Gardner, P., Wright, J., & McEachan, R. R. C. (2012). ;[Identifying the latent failures underpinning medication administration errors: An exploratory study](http://library.capella.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=aph&AN=77510082&site=ehost-live&scope=site). ;*Health Services Research, 47*(4), 1437–1459.
		- This examination of underlying systemic causes of medication errors may be useful as you consider QI best practices and ways to coordinate care to increase safety and quality.

# Resources: Quality and Safety Education

* PRINT
* Quality and Safety Education
	+ Dolansky, M. A., & Moore, S. M. (2013). [Quality and safety education for nurses (QSEN): The key is systems thinking](http://library.capella.edu/login?qurl=https%3A%2F%2Fsearch.proquest.com%2Fdocview%2F1545822285%3Faccountid%3D27965). *Online Journal of Issues in Nursing*, *18*(3), 71–80.
		- The need for implementing systemic quality improvement practices to improve patient safety and quality is discussed in this article.
	+ Lyle-Edrosolo, G., & Waxman, K. (2016). [Aligning healthcare safety and quality competencies: Quality and safety education for nurses (QSEN), the Joint Commission, and American Nurses Credentialing Center (ANCC) Magnet® standards crosswalk](http://www.sciencedirect.com.library.capella.edu/science/article/pii/S1541461215002293). *Nurse Leader, 14*(1), 70–75.
		- This article attempts to align the language used in three quality and safety standards and reduce confusion for health care professionals.
	+ Masters, K. (2016). [Integrating quality and safety education into clinical nursing education through a dedicated education unit](http://www.sciencedirect.com.library.capella.edu/science/article/pii/S1471595315002061). *Nurse Education in Practice, 17*, 153–160. doi:10.1016/j.nepr.2015.12.002
		- Masters discusses how nursing students' participation in a dedicated safety and quality educational unit resulted in higher project evaluations than those of students who participated in traditional clinical rotations.
	+ Rosenblum, R. K., & Sprague-McRae, J. (2014). [Using principles of quality and safety education for nurses in school nurse continuing education](http://library.capella.edu/login?qurl=https%3A%2F%2Fsearch.proquest.com%2Fdocview%2F1508544408%3Faccountid%3D27965). *The Journal of School Nursing*, *30*(2), 97–102.
		- This article, which examines evidence-based and best-practice strategies for improving the care offered by school nurses, may help you identify useful strategies for your assessment.

# Resources: Quality and Safety Case Studies

* PRINT
* Quality and Safety Case Studies
Consider reviewing the following case studies as you complete your assessment:
	+ 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/WhatHappenedtoJosiResources: Program Resources
* PRINT
* Capella Writing Center
	+ [Introduction to the Writing Center](https://campus.capella.edu/web/writing-center/home).
		- Access the various resources in the Capella Writing Center to help you better understand and improve your writing.
* APA Style and Format
	+ Capella University follows the style and formatting guidelines in the *Publication Manual of the American Psychological Association,* known informally as the APA manual. Refer to the Writing Center's [APA Module](http://campustools.capella.edu/redirect.aspx?linkid=2586) for tips on proper use of APA style and format.
* University Library
	+ [BSN Program Library Research Guide](https://capellauniversity.libguides.com/BSN).
		- The library research guide will be useful in guiding you through the Capella University Library, offering tips for searching the literature and other references for your assessments.
	+ eKing.aspx

# Activity: Identifying Safety Risks and Solutions

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### [IDENTIFYING SAFETY RISKS AND SOLUTIONS](https://courserooma.capella.edu/webapps/blackboard/execute/blti/launchLink?course_id=_267495_1&content_id=_9122626_1)

* Click the linked title above, Identifying Safety Risks and Solutions, to complete this formative activity, which offers an opportunity to review a case study and practice identifying safety risks and possible solutions. These skills will be necessary to complete the Enhancing Quality and Safety assessment successfully. This is for your own practice and self-assessment.

# Identifying Safety Risks and Solutions



The below scenario comes from the state of Minnesota Department of Health’s [Root Cause Analysis Toolkit](http://media.capella.edu/CourseMedia/nurs-fpx4020element16441/documents/5fall_casestudyrev101513.pdf).

For the following questions, consider the following scenario:



62 year old female with history of congestive heart failure (CHF) was admitted from the Emergency Department with Left Lower Lobe Pneumonia. She has been living independently at home with no assistance needed with cares. She was complaining of pain with inspiration, vital signs were normal, oxygen saturation was 90% on room air. On hospital day 2, she was found on the floor at 2345 in severe pain. X-rays revealed a hip fracture. The next day she was taken to surgery for repair. During surgery she had an acute myocardial infarction (AMI) and expired while on the table.

Further analysis of the timeline leading up to 2345 discovered that the nurse came on at 2300 that evening and got report which indicated the patient was pleasant and cooperative, asking for help as needed, didn’t attempt to get up on her own, used the call light. Looking at the medical record found the patient had been given a sleeping pill and pain medication at 2200, the same as the previous night. The patient doesn’t regularly take either a pain or sleeping pill at home.

At 2330, the nurse checked the patient to do vital signs, found her dozing but easily arousable although a little confused when first awakened. The unit became busy as they just received a fresh surgical patient post operatively.

At 2345, a nurse walking by the room heard a noise and went to investigate. She found the patient on the floor and called for help. The patient had been incontinent of bed and gown, the floor was dry. They had to move furniture in the room to get at patient as there were extra chairs in the room after her family visited that evening. Her oxygen tubing was wrapped around her IV pump. The physician came immediately and assessed the patient. X-rays were ordered and the patient was taken to x-ray. The x-rays revealed a hip fracture. Orthopedics saw the patient and scheduled her for surgery the next day. She was prepared for surgery and sent the next day.

**Question 1 of 4**

What are some questions that the team investigating this adverse might want to ask as they investigate?

**Question 2 of 4**

What were the biggest patient safety risks based on the information available?

**Question 3 of 4**

Choose one of the patient safety risks you identified in the previous question. How did that risk factor contribute to the adverse events in the scenario?

**Question 4 of 4**

What is one evidence-based solution or strategy that could help mitigate the risk factor(s) you have identified?

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