

CULTURE ENSURES THAT MEDICAL FACILITIES ARE BOTH SAFE AND PROVIDING EXCEPTIONAL CARE

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Abstract

The major aim of patient care and quality management is to ensure patient safety. Beauchamp and Childress's four principles of biomedical ethics constitute a quality management model that underscores the significance of the patient. The six improvement goals established by the Institute of Medicine encapsulate the fundamental principles of exemplary medical care. The Institute for Healthcare Improvement's Triple Aim is founded on three pillars: care, money, and health. This review was composed considering the aforementioned contexts, aiming to emphasize the system's actions to improve quality and patient safety. We offer a comprehensive analysis of healthcare legislation, policy, and regulation, focusing particularly on the concepts of informed consent and informed refusal. This analysis delineates the measures implemented and restrictions enforced by the administration and management to deliver patient-centered care. We will examine model policies such as the Delivery System Reform Incentive Payment Program, which integrates quality management frameworks; the Hospital-Acquired Conditions Reduction Program, which enhances patient safety; and the Hospital Readmissions Reduction Program, which seeks to minimize hospital readmissions.

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

Background

Numerous elements, including the optimization of high-quality care, influence the logistics of patient care and healthcare administration. Accreditation by The Joint Commission (TJC), performance excellence recognized by the Malcolm Baldrige National Quality Award (MBNQA), and nursing excellence awarded by the Magnet Recognition Program all signify a superior standard of care [1–3]. TJC is the preeminent authority in global healthcare accreditation. This non-profit organization may objectively assess the quality of performance in patient care and safety [4]. The MBNQA is the premier presidential accolade in the nation for quality and efficiency. The Magnet Recognition Program was established to acknowledge and reward global enterprises whose nursing leadership has effectively integrated strategic nursing goals to enhance patient outcomes. The Institute of Medicine (IOM) further categorizes care delivery domains with its six priorities for improvement, alongside the previously described healthcare acknowledgment [7]. The Triple Aim, formulated by the IHI, seeks to improve care quality, population health, and the efficiency of individual healthcare expenditures. This document presents a summary of the convergence of biomedical ethics, the Six Aims for Improvement, and the Triple Aim in prioritizing patient safety and enhancing treatment quality. This article will examine the clinical and managerial duties

associated with protecting patient safety in both urgent and everyday circumstances. This study aims to exemplify contemporary policies that foster patient-centered care while preserving standards that improve treatment, ensure quality, and enhance safety. Patient safety is crucial for healthcare providers due to its essential role in delivering effective medical care. Clinicians administer direct treatment to patients. Does this imply that politicians, leadership, and managers function independently of patient safety considerations? Given that these organizations formulate and execute rules to uphold and enhance patient safety within their respective municipalities, institutions, and departments, a response of "no" is a highly realistic answer to the aforementioned question. Micro-level executives, managers, and physicians are accountable for implementing, adopting, and executing macro-level healthcare policies established and advised by policymakers.

Research questions and objectives

The biomedical ethical principles proposed by Beauchamp and Childress, the six objectives for enhancement, and the Triple Aim exemplify the quality management frameworks delineated in the extant literature. Each of the aforementioned models considers patients' desires and requirements while also facilitating improvements in healthcare delivery. In certain instances, patients who present while unconscious or intoxicated are incapable of articulating their treatment preferences. Initially, considering the previously indicated scenario, what alternatives should physicians contemplate as safe harbors when managing such patients? The second inquiry is, "What options do clinicians have when a patient provides or denies consent?" The third line of inquiry logically extends from the second; particularly, what role does the administration assume in implementing policies not addressed by current legislation? This analysis has three objectives. Initially, drawing from the principles of informed consent and informed refusal, we aim to propose solutions about the appropriate actions and prohibitions that clinicians may adopt in both emergency and non-emergency contexts. Secondly, we aim to elucidate how hospital management might enhance the quality of patient care while concurrently mitigating health hazards. Ultimately, we analyze model policies that have recently been enacted as components of systemic initiatives aimed at ensuring patient safety and enhancing care delivery measures. The list comprises 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

Medical and surgical faculty play a vital role in cultivating a culture of safety in patient care. Four biological ethical considerations are pertinent in this context. The ideals encompass "self-determination," "non-maleficence," "beneficence," and "justice." [9]. The four tenets, referred to as the "four pillars of medical ethics," provide the foundation of ethical medical practice. Ethical medical and surgical decision-making considers additional facets of biomedical ethics derived from the previously listed four principles [10]. This is a summary of some auxiliary features:[10]. Integrity, Information Completeness, and Privacy: Full disclosure is offering precise and thorough information regarding the patient's medical state, whereas sincerity involves refraining from distorting the facts when communicating with the patient. Confidentiality pertains to the principle of maintaining the secrecy of a patient's health information. The term "autonomy" refers to the notion of granting the patient complete authority over all medical decisions. This idea is crucial in

contentious issues such as abortion and end-of-life care [10]. Beneficence denotes the act of assisting a patient while minimizing potential harm.

The Institute of medicine's six aims for improvement model

The AHRQ Patient Safety Network defines harm prevention as "freedom from accidental or preventable injuries produced by medical care," offering a more comprehensive understanding of the concept [11]. The IOM proposed six objectives for the improvement of healthcare to more effectively address patients' needs while ensuring their safety. The six objectives are as follows: [7]. Safe signifies that treatment will not inflict harm on patients rather than providing assistance. When patients witness the implementation of steps that foster a secure environment, patient safety can evolve into a comprehensive approach across the system [7]. Efficient denotes the avoidance of waste in terms of time, money, resources, or energy. Defensive medicine, malpractice litigation, systemic complexity, and administrative fraud and abuse exemplify healthcare waste. Possibly enhancing healthcare efficiency and providing cost-effective care [7]. Efficient: guaranteeing that all individuals who could gain from a service obtain that service. data-based medicine entails making medical decisions grounded in the most reliable scientific data. Patient-centered care acknowledges and meets the distinct goals, interests, and values of each individual patient. Care is considered patient-centered alone when the patient possesses autonomy over their own care. This patient care strategy is prospective since it integrates elements of teamwork and communication [7]. Reducing unnecessary delays for both patients and doctors. The quality of patient care may deteriorate universally due to prolonged waiting times and perilous delays [7]. Care that maintains consistent quality and is devoid of discrimination based on demographic attributes such as ethnicity, socioeconomic status, gender, etc., is deemed equitable [7]. To fulfill the initial goal of the IOM's six objectives for enhancement, healthcare providers must ensure the safety of their processes. Secondly, to enhance future efficacy, patient care must align with contemporary research. Third, the patient's cultural background, dietary habits, and personal preferences are considered in the provision of care. The aforementioned concept is essential to the hospice care provided to the terminally ill. Timely delivery and reception of care necessitates the reduction of patient wait times. Unexpected delays in therapy can inflict considerable collateral damage on patients. Timely provision of care is essential for ensuring patient wellbeing. Reducing inefficiencies and duplications can alleviate pressure on constrained healthcare expenditures. Equitable care refers to treatment that remains consistent irrespective of socioeconomic status, race, ethnicity, or financial level.

The Institute of healthcare improvement's triple aim model

The Triple Aim concept, created by the Institute for Healthcare Improvement (IHI), considers care, cost, and health outcomes. The Triple Aim framework established by the IHI encompasses three objectives: [8]. A method to assess patient satisfaction with their care is through surveys such as 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) aids in the prevention of healthcare fraud and abuse while promoting high-quality medical care. Healthcare expenditure on an individual level can be diminished by using strategies such as prescribing cost-effective generic medications instead of pricier brand-name pharmaceuticals [8]. Advancing communal well-being [8]. The Triple Aim is a conceptual framework established by the IHI to delineate a strategy comprising three interrelated objectives. Our priorities include improving population health, augmenting the quality of individual care, and reducing per capita healthcare costs by eliminating waste and variability. The IHI's Triple Aim strategy, because to its extensive applicability, can alleviate administrative

difficulties linked to the promotion and maintenance of population health and wellness. Innovations in medical technology that enhance the patient experience of care are categorized under the first pillar of the Triple Aim, which emphasizes the improvement of care experiences [8]. Implementing telemedicine and telehealth initiatives, for example, supports the second element of the Triple Aim by reducing per capita healthcare costs. When physicians are unable to be present physically, telemedicine facilitates prompt and efficient treatment. Telemedicine offers the advantage of enhancing patients' access to medical care. Conversely, it elucidates this to physicians and patients who may lack familiarity with e-health. The third component of the Triple Aim, enhancing population health, is pertinent to facilitating the achievement of the initial two objectives. The IHI's Triple target model is a triadic framework, wherein the initial two objectives are fundamental to the third target, which is to enhance 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) requires that all patients arriving at an emergency room receive stabilization and treatment, irrespective of their insurance status or financial means [15]. Patients possess the right to get care, and medical practitioners are obligated to provide it in accordance with EMTALA [15]. Consider an unconscious emergency room patient who is averse to the notion of receiving a blood transfusion. Was patient-centered care administered in the aforementioned scenario if the treating physician, oblivious to the unconscious patient's cultural preferences, conducted a blood transfusion to resuscitate the patient? The provider's assessment within the framework of EMTALA is likely the area to investigate for a resolution. The examination primarily concerns the clinician's legal obligation to treat all patients, particularly in emergency circumstances. In non-emergency contexts, where patients and physicians possess autonomy in selecting their providers, the previously mentioned hypothetical scenario assumes a markedly distinct dynamic. This is because a physician-patient contract is founded on the nature of the doctor-patient relationship [16]. The connection between the doctor and the patient is controlled by contract law, as the doctor has contractually committed to provide treatment in return for payment. In the absence of a formal agreement between the physician and the patient, the physician bears no legal obligation to render care [16]. The phrase "informed consent" is a phase in the medical care process when the physician imparts information to the patient regarding the forthcoming treatment and deliberates its associated risks and advantages. In 1914, American judge Benjamin Cardozo asserted, "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," establishing the foundation of informed consent [18]. The concept of "Informed Refusal" was established to tackle the specific scenario in which a patient withholds consent for treatment in a non-emergency context [19, 20]. The patient will enumerate their end-of-life desires in a living will as an illustration of an informed refusal document [21]. In the specified scenario, the provider honors the patient's preferences about end-of-life care and/or abstains from treatment in alignment with the living will. Leadership is responsible for enforcing EMTALA and aiding physicians in understanding informed consent and informed refusal protocols throughout organizations. Furthermore, they ensure that healthcare staff adhere to the previously mentioned patient preference policies. Leadership possesses the right to establish regulations in medical contexts when no existing laws apply, yet they must exercise caution to avoid contravening 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

The Delivery System Reform Incentive Payment (DSRIP) program exemplifies a prototype statute that implements the Triple Aim framework and encompasses all six developmental objectives. DSRIP encompasses many healthcare projects that improve health outcomes through multiple indicators and milestones in primary care, specialty care, chronic care, navigation and case management, disease prevention and wellness, and general categories. When adopted by healthcare institutions, these projects receive systematic funding from the State Department of Health [22–26]. The DSRIP framework comprises four components: (1) Infrastructure Development, (2) Program Innovation and Redesign, (3) Quality Improvement, and (4) Enhancement of Population Health in states where its programs are executed [22–26]. In its third year of operation, the Texas DSRIP program encompassed around 172 projects across eight cohorts: primary care, emergency care, chronic care, navigation/case management, disease prevention and wellness, behavioral health/substance abuse prevention, and general care.[22, 23, 25] The IOM's six objectives for patient care—safety, effectiveness, efficiency, patient-centeredness, timeliness, and equity—were concurrently integrated into the specified number of projects for each cohort, which entailed achieving patient care milestones and indicators [22–25]. DSRIP has been shown to enhance population health through the implementation of all its activities in the designated areas and counties [25]. The DSRIP initiative utilized the preventable hospitalization rate as a metric to assess advancements in population health [24]. The dynamics and foundational structure of the DSRIP policy may have influenced the reduction in preventable hospitalization rates [23, 24]. The dynamics encompassed interacting healthcare externalities, incentive payment systems, outcome measurement types for quality reporting, and collaboration between physicians and administrators [24]. An interrupted time series analysis revealed a statistically significant decline in preventable hospitalization rates in the designated regions and counties [25]. The Texas DSRIP program was segmented into two phases: 1.0 and 2.0. Comprehensive Diabetes Care: the eye exam measure rose by 16% in DSRIP 2.0, whereas influenza immunization increased by 12% in the latter period [27]. Researchers Revere et al. discovered that the rates of catheter-associated urinary tract infections (CAUTI), surgical site infections (SSI), and central line-associated bloodstream infections (CLABSI) 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 established, concentrating on three objectives: care, cost, and health. In 2015, Sikka and associates established a fourth objective: improving the caregiving experience. This aimed to acknowledge the importance of doctors, nurses, and all other staff in "discovering joy and meaning in their work, thus enhancing the experience of delivering care." [28]. The experience of joy and purpose in caregiving is central to the fourth aim, equating it with achieving fulfillment and meaning in their endeavors. The Quadruple Aim has significant implications for both theory and practice, emphasizing inclusivity for all members of the healthcare workforce [28].

Hospital-Acquired conditions reduction program: focusing on patient safety

The Centers for Medicare & Medicaid Services' continuous endeavor to link Medicare reimbursements to healthcare quality in inpatient hospital environments is bolstered by the Hospital-Acquired Conditions Reduction Program (HACRP), a Medicare pay-for-performance project. Healthcare-associated infections (HAIs), as quantified by the National Healthcare Safety Network (NHSN) of the Centers for Disease Control and Prevention (CDC), include the following:

30 (1) Central Line-Associated Bloodstream Infection (CLABSI), (2) Catheter-Associated Urinary Tract Infection (CAUTI), (3) Surgical Site Infection (SSI) during colon and hysterectomy procedures, (4) Methicillin-Resistant Staphylococcus aureus (MRSA) bacteremia, (5) Clostridium difficile Infection (CDI). Furthermore, the program encompasses eight Patient Safety Indicators (PSIs), which consist of: [31] 1. PSI 03 - Pressure Ulcer Rate; 2. PSI 06 - Iatrogenic Pneumothorax Rate. PSI 07 - Central Venous Catheter-Associated Bloodstream Infection Rate, PSI 08 - Postoperative Hip Fracture Rate, PSI 12 - Perioperative Pulmonary Embolism or Deep Vein Thrombosis Rate, PSI 13 - Postoperative Sepsis Rate, PSI 14 - Postoperative Wound Dehiscence Rate, PSI 15 - Accidental Puncture or Laceration Rate.

Hospital readmissions reduction program: focusing on patient safety

The Hospital Readmissions Reduction Program (HRRP), a Medicare value-based purchasing initiative, reduces payments to hospitals with excessive readmission rates. The project links remuneration to the quality of hospital care, so promoting the national goal of improving healthcare. To reduce readmissions, hence enhancing patient safety, HRRP concentrates on the following issues: [32]. The 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).

Conclusion

This review aimed to investigate patient safety through the lens of the previously described quality management frameworks. We specifically incorporated instances of legislation and practices such as EMTALA, informed consent, informed refusal, and living wills. Although EMTALA standards are applicable in emergencies, acquiring the patient's informed permission remains essential in non-emergency circumstances. Should the patient refuse therapy, it is advisable to document their informed refusal. Emphasizing the initiatives the system has implemented to bolster patient safety and elevate care quality, we underscored several emerging prototype policies transitioning from national policymaking to institutional levels.

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