Project Translation and Planning

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Patient safety is an essential component of quality nursing care. The patient safety plan is important to reduce the risk associated with patient safety (Swanson & Tidwell, 2011). The main objectives of this project are

* To facilitate the reporting, communication, and documentation of medicine-related errors
* To enhance effective clinical and organizational decision making.
* To encourage an environment that facilitates patient safety and identification of medication errors.
* To establish the knowledge of patient safety among nurses.

**Measures**

The root cause analysis will be done to determine the reason for the under-reporting of medication error by the nurses. Interviews from nurse leaders and staff will be conducted to assess the knowledge they possess regarding patient safety. The change will be measured by monitoring the regulatory compliance indicators such as medication errors, adverse drug reporting trends, behavioral management, the culture of safety, the incidence of adverse drug reaction and mortality associated with the adverse drug event. The patient safety plan will be flexible to accommodate the significant structural and service changes.

**People**

Board of directors: They will have the main responsibility for the patient safety quality plan and its performance and reporting.

Clinical Leadership: Expert clinicians, nurse leaders, and other health care professionals will provide their expert opinion on how should optimum patient safety can be achieved.

**Resources**

To facilitate patient safety in a hospital, the quality management department will assist the physicians and staff with the identification of proper resources of data. The proper medication error reporting form will be freely available. Nurses will have access to software in which record of all medication error is present and a conference room in which nurses and other health care professions will be given training.

**Leadership theories**

Change is a very important component of the nursing profession. Leading change is a challenge for nurse leaders to advance and refine their management and leadership skills. Change initiatives must be implemented to achieve objectives of providing optimum patient care. The safety of the patient is the key to quality health care. The transformational leadership style can play a very important role in creating an environment that is conducive to the safety of the patient. In this leadership style, nurse leaders respect and motivate other staff to report medication errors and to practice patient safety. Force field model is theorized by the Kurt Lewin. It is a three-stage model of change to identify the forces and factors that influence a situation. According to this theory, it is necessary for leaders to reject prior knowledge and to replace it with some new information. The change involves a process of changed behavior, feelings, and thought from a planning phase to monitoring (Lorch, 2019). According to the innovation diffusion theory, if a change is not successful in achieving the desired result, then that change can be resurrected later at a more appropriate time and in a more appropriate forum. Both of these theories help to achieve patient safety in a hospital setting.

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| **Goals** | **Actions** | **Monitoring** | **Responsibility** | **Time Frame** |
| Improve compliance to hand hygiene thereby reducing the hospital-acquired infection and keeping the patient and staff safe | Regularly audits will be done;  Rates of hand hygiene and another indicator of infection control will be posted quarterly. | Rates of hand hygiene will be reviewed every month.  Metrics of infection control will be posted 4 times in a year. | Nurse leader, | January 2019 |
| To ensure an accurate and complete medication reconciliation for all staff and patients | Develop reconciliation education program on safe medicines for staff  Develop a culture that promotes patient safety and increase reporting of the medicine error | More than 80% of the staff completed the training on patient safety. | Nurse leader, Staff development coordinator. | Ongoing process |
| Adhere to the recommendations of safe administration of medicines. | Telephone follow-up and Retrospective chart audits will be done  Meet standards for sterile preparation | Medicine error will decrease. | Nurse leader, Staff development manager, Pharmacist | December 2019 |
| Encourage an environment that facilitates patient safety and identification of medication errors. | Incentives will be given to those nurses who will report adverse drug reactions.  Training sessions regarding patient safety will be conducted after every one month. | Length of stay of the patient due to medication error decreases.  More nurses start reporting medication error which they encounter in their daily practice  Hospital admission due to adverse drug event will reduce by 15% | Nurse leader, Pharmacist, Physicians | April 2019 |

**References**

Lorch, A. (2019). Implementation of fasting guidelines through nursing leadership. *Practice nursing, 7*, 00.

Swanson, J. W., & Tidwell, C. (2011). Improving the culture of patient safety through the Magnet® journey. *The Online Journal of Issues in Nursing, 16*(3).