NURS FPX 4020 Assessment 1

Enhancing Quality and Safety

Delivery of a health care system is dependent on its ability to provide the correct and safe care to attain optimal outcomes for an individual patient. Diagnosis errors bring out tremendous problems, which lead to negative consequences for patients as well as healthcare costs (Rodziewicz et al., 2023). This paper discusses all the aspects that will most likely affect diagnostic errors, such as systemic, cognitive, and communication-related factors. Effective solutions proven by evidence and the role of nurses in tying up the gaps to guarantee safe and effective patient care while reducing the cost linked to documentation will be discussed and attention will be drawn to the participation of stakeholders in this process.

Factors Leading to Diagnostic Errors in Healthcare

Diagnosis is the most critical error in healthcare, forming the chief patient rationalization and rooted in a systemic, cognitive, and communication cause. As stated by the National Academy of Medicine, diagnostic mistakes afflict about twelve million Americans a year, leading to adverse health outcomes, unwarranted treatments, and increased healthcare costs (Newman-Toker et al.,2019).

Problems with various types of diagnostic inaccuracies are directly associated with failures in diagnostic systems. Inadequate availability of diagnostic test facilities, scarcity of physicians with specialized knowledge, and poor follow-up care negatively impact the diagnostics process and increase the possibility of errors; thus, diagnosing one accurately and timely may be difficult (Meyer et al., 2021). Such delays in getting results by doing diagnostic imaging or lab tests in which the equipment is in need of supply or needs more time might cause the diagnosis to be missing or delayed.

Cognitive biases, such as anchoring, confirmation bias, and availability analytical, drag healthcare professionals like neurologists, anesthetists, and other practitioners. This negatively impacts clinical reasoning and decision-making; these biases can trigger the process of ruling out some diagnoses early or neglect the possibility of different diagnoses, thus resulting in incorrect diagnoses (Abimanyi-Ochom et al., 2019). Similarly, anchoring occurs when providers? Impressions for a disease are focused much more on symptoms shown at the onset instead of other possible contradictions and differentiations from similar diseases.

Deficiencies, which usually are associated with poor communication among healthcare team members, patients, and caregivers (providers and families), result in diagnostic errors through the processes of disruption of information sharing and collaboration. Integrity of information transmitted, incompatible matters between care transitions, or language problems result in wrong inference and diagnosis (Tariq et al., 2023). One of the scenarios on the issue of miscommunication involves patients who have concerns about the history of their diseases having the wrong contemplations and leading to an improper diagnosis.

Diagnostic mistakes in health institutions touch various areas, namely systemic failures, cognitive distortions, and communication gaps. These factors need an integrated instrument that bears system-based improvement, cognitive debiasing styles, and effective protocols for diagnosis to enable clinicians to diagnose patients on time, reducing the risk of medical errors (Hartigan et al., 2020).

Evidence-Based Solutions to Enhance Patient Safety and Reduce Costs

Enforcing proof-based and best practice actuation is paramount for patient safety and cost reduction in the healthcare environment. Studies have discovered some practical approaches that both increase safety and ensure resource use is wisely invested.

Standardized protocols and clinical guidelines have gained popularity because they promote standardized delivery of care, which improves patient safety by reducing the variability in care and creating a uniform system. For example, the Institute for Healthcare Improvement (IHI) promotes the use of standardized protocols with respect to the administration of drugs, provision of hand hygiene, and procedures such as surgeries to attain uniformity and minimize the number of errors (Institute for Healthcare Improvement) (Kohn et al., 2022). Strictly adhering to evidence-based processes helps reduce risks connected with the implementation of unproven, non-recommended procedures and thus allows better patient care while decreasing costs due to adverse events.

Collaboration and teamwork among healthcare professionals in dealing with health and safety issues assist in the expansion of communication networks, increase the coordination of care, and improve the culture of safety. The studies have confirmed that the elements of teamwork and appropriate communication are precisely needed to avoid patient errors and enhance safety (Salas et al., 2022). For example, ward rounds may be used to facilitate the communication and sharing of information, the making of collaborative decisions, and problem-solving. These may lead to more comprehensive patient evaluations with fewer adverse events. Collaborative practice is a vital element and the source of better resource allocation and prevention of every possible mistake, which maximizes healthcare organizations’ costs.

Technology platforms, comprising of electrical health records(EHRs) and decision support systems, can significantly leverage patient safety by having real-time access to patient data, clinical guideline sets, and decision-making. According to the systematic study of the efficacy of the decision-support system performed by (Kilsdonk et al. 2020), the level of safety and quality is increased when these decision-support systems are used, thus reducing medication errors and adverse drug events. Apart from that, the incorporation of barcode medication administration systems and electronic prescribing abilities facilitates favorable safety of medication and cuts down medical errors and related adverse events costs (Poon et al., 2020).

Nurses' Role in Coordinating Care to Enhance Patient Safety and Reduce Costs

Through collaborative care and management, nurses and caretakers can contribute primarily to increasing patient safety and cutting costs in healthcare systems. They amplify the voices of patients without their ability to express their desires. Diagnosis errors, for example, should not be ignored, and nurses can play a vital part by talking to the doctors and caregivers to confirm that the information about their patients is always passed clearly (Kwame & Petrucka, 2020). Nurses provide the clinical support necessary for the effective detection and prevention of diagnostic errors through their role in pushing for timely assessments and prompt interventions. This is done primarily by ensuring that early detection and minimizing the economic costs that come with inappropriate or delayed diagnoses are aided, hence better patient safety.

As coordinators of work duties among different departments and healthcare sites, nurses try to ensure continuity of service to patients. In the process of diagnostic errors, nurses can be one of the ways to help make the smooth transition between inpatient facility and outpatient clinic to avoid delays such that diagnostic test findings are always communicated to the appropriate healthcare providers (Patterson et al., 2020). This is done by arranging follow-up appointments, monitoring patients' progress, and facilitating communication between healthcare professionals. The nurses help to fill the gap in care and consequently reduce the opportunities for diagnostic errors that would lead to increased healthcare costs and give no results in our community.

Nursing practice as an educator is one facet that nurses play a very significant role in. They emphasize clarity about the various aspects of the health of patients, treatment options, and as much as can be done by a patient to be actively involved in their healthcare journey. With regards to diagnostic misinterpretations, nurses may instruct the patients on the necessity of obtaining a second opinion, questioning diagnostical results and the treatment plan, and asserting their healthcare issues (Benbassat, 2019). By educating patients to be well-informed participants in their care plans, nurses reduce diagnostic errors, identify health issues early, and lower the number of unneeded healthcare services both for patients and the healthcare system.

Stakeholders for Quality and Safety Enhancements in Healthcare

The nurses take part in multi-axial work with various stakeholders to improve change in quality and safety in the setting of health care while focusing on specific safety issues such as wrong diagnosis. Every stakeholder is featured in the form of words, knowledge, and tools they bring to the table, so the holistic solution, which is centered on patient safety and good results, becomes the click.

Physicians are the primary professional group involved in the detection and review of diagnostic errors since they are the ones who make the decisions of care and interpret the diagnostic tests (Cantey, 2020). Collaboration with physicians is critical, as it helps nurses communicate crucial patient details, give a report on symptoms and observations, and fight so that the tests are comprehensive enough. Through the promotion of open communication and interspecialty collaboration, doctors and nurses will be more able to allow for diagnoses error reduction, patient safety enhancement, and diagnostic accuracy improvement.

Administrators of healthcare and quality improvement teams become the masters of policies and reforms that should be implemented in the healthcare system in order to minimize the number of diagnostic mistakes and make patient care safer in general. By working closely with these stakeholders to determine those areas that are best suited for improvement through evidence-based practices and outcome-monitoring quality improvement initiatives. Nurses form an integral part of the healthcare team. Interacting with healthcare administrators, the funds and resources will be allocated, the burdensome processes will be streamlined, and the organizational cultures will be revisited with patient safety in mind (Booth et al., 2021).

The contribution of patients and their family members in the healthcare process can be significant because they share their experiences, wishes, and the issues they are facing while in the healthcare process. Nurses are the most trusted healthcare professionals because they connect with patients and relatives to deliver them. This kind of information allows them to be involved in the decision-making process about their patient's medical conditions; it shows them how to be active participants in their care (U.S. Department of Health & Human Services, 2022). The nurses expand the scope of communication, and they encourage transparency. The chance of errors in the diagnosis process is minimized because of increased engagement with patients and families.

Conclusion

The systemic challenges of diagnostic errors have to be addressed holistically and comprise evidence-based solutions, interdisciplinary collaboration, and regular involvement of the stakeholders. Nurses are undeniably at the helm when it comes to their inimitable role of tying care, putting forward advocacy, and helping with communication among healthcare workers, patients, and families. With their ability to smooth the path, faculty nurses play a crucial role in decreasing occurrences of patient safety risks, maximizing resource usage, and building effective, economically sound care. Clinical expert nurses, in collaboration with other key players, are able to influence higher standards of quality and safety, which consequently result in improved patient outcomes and reduced healthcare expenditures.

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