Nursing & Health Sciences | BSN | Assessment 4

Free NURS-FPX4020 Assessment 4: Improvement Plan Tool Kit

Complete Distinguished-Level Model Sample

Course code	NURS-FPX4020
Course	Improving Quality of Care and Patient Safety
Deliverable	Annotated improvement-plan tool kit with 12 professional and scholarly resources
Quality-improvement focus	Closed-Loop Insulin Medication Safety Bundle
Author metadata	Flexpath assignment help

Model scenario notice. The patient, clinical unit, baseline data, event details, and performance results in this sample are fictional. They are used to demonstrate complete academic analysis without representing an actual patient or organization.

How to use this sample. Study the organization, evidence integration, clinical reasoning, and alignment between the root-cause analysis and the improvement plan. Do not submit this file as your own work. Replace the hypothetical details with your own course-approved scenario and original analysis.

Canonical sample page

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Improvement Plan Tool Kit: Closed-Loop Insulin Medication Safety Bundle

Purpose and intended users. This tool kit gives adult medical-surgical nurses, charge nurses, educators, pharmacists, quality staff, and implementation leaders practical evidence for reducing insulin administration risk. It supports the same improvement plan developed after a fictional wrong-patient insulin event. The resources are grouped into four categories so users can quickly find standards, BCMA evidence, human-factors research, and implementation support.

How each annotation is organized. Every entry explains what the resource provides, why it matters for the improvement plan, and how or when nurses should use it. This format turns a reference list into a working implementation tool. The final decision about policy must also consider current institutional procedures, state requirements, technology configuration, and verified local data.

Quick-start use. Begin with Category 1 when building the business case and policy. Use Category 2 while mapping the barcode workflow and designing downtime safeguards. Use Category 3 when redesigning interruptions, reporting, and safety culture. Use Category 4 to plan education, teamwork, priorities, and sustainment.

Tool Kit Categories

Category	Focus	Use in the plan
1	Standards and high-alert medication safety	Policy, accreditation, high-alert safeguards
2	BCMA and closed-loop workflow	Technology use, workarounds, workflow design
3	Human factors, interruptions, and learning culture	Contributing conditions, nurse experience, reporting
4	Education, teamwork, implementation, and sustainability	Competency, interprofessional roles, prioritization

Category 1: Standards and High-Alert Medication Safety

1. World Health Organization - Medication Without Harm Policy Brief

World Health Organization. (2024). *Medication without harm: Policy brief*. https://www.who.int/publications/i/item/9789240062764

What this resource provides. This policy brief presents medication safety as a global systems problem and connects avoidable medication harm to actions across prescribing, dispensing, administration, monitoring, and transitions. It is a high-credibility international source because it synthesizes policy priorities for health systems rather than promoting one product or local workflow.

Why it matters for the improvement plan. The Closed-Loop Insulin Medication Safety Bundle needs a clear reason for action beyond one local incident. This source helps nurses and leaders explain that medication harm is preventable and requires coordinated change. It supports the bundle's combination of technology, human-factors controls, patient involvement, education, and monitoring. It also reinforces the idea that the event should be treated as a system learning opportunity instead of an isolated individual failure.

How and when nurses should use it. Use this resource during the opening of the in-service, leadership approval, policy revision, and annual patient-safety education. Nurses can use its broad framework to connect bedside concerns with organizational goals. It is most useful for explaining why the team is changing the whole medication-use process. It is less useful as a step-by-step bedside procedure, so it should be paired with the unit

workflow and competency checklist.

2. ISMP Targeted Medication Safety Best Practices for Hospitals

Institute for Safe Medication Practices. (2024). *2024-2025 ISMP targeted medication safety best practices for hospitals*. https://www.ismp.org/guidelines/best-practices-hospitals

What this resource provides. The ISMP best-practice document translates medication-safety learning into specific organizational actions. It focuses on recurring, serious risks and emphasizes standardization, high-alert medication safeguards, technology optimization, and organizational accountability. ISMP is a specialized medication-safety authority, which makes this source especially useful for policy and risk-control decisions.

Why it matters for the improvement plan. The source supports layered safeguards for insulin, including reliable technology, clear procedures, and practices that do not depend on one clinician catching every risk. It strengthens the rationale for targeted independent checks, storage and labeling controls, meaningful override review, and leadership oversight. Because insulin can cause rapid severe harm, the plan should use more than one defense.

How and when nurses should use it. Nurse leaders, pharmacists, educators, and practice councils should use this document when writing or revising the insulin policy, defining independent-check criteria, and assessing current gaps. Bedside nurses can use the local quick-reference version derived from the policy rather than navigating the full document during a medication pass. Revisit the source during annual policy review and after any serious insulin event.

3. The Joint Commission National Patient Safety Goals

The Joint Commission. (2025). *National Patient Safety Goals effective January 2026 for the hospital program*. https://www.jointcommission.org/standards/national-patient-safety-goals

What this resource provides. The National Patient Safety Goals identify core expectations for patient identification, communication, medication safety, and prevention of avoidable harm in accredited organizations. The source is an authoritative standards resource rather than a research study. It helps organizations connect local interventions to external safety expectations and survey readiness.

Why it matters for the improvement plan. The wrong-patient insulin event directly involves patient identification and medication safety. The goals reinforce using reliable identifiers, maintaining safe medication processes, and reducing known safety risks. They support the plan's emphasis on wristband verification, bedside scanning, clear communication, and structured review of unsafe conditions.

How and when nurses should use it. Use the goals during leadership briefings, policy crosswalks, orientation, and audit design. Nurse educators can map each workflow step to a recognized safety expectation. Quality staff can use the source when explaining why scan compliance alone is not enough; the organization must also address communication, technology exceptions, and learning from events. Always check the current year's version before final policy approval.

Category 2: Barcode Medication Administration and Closed-Loop Workflow

4. Mulac et al. - BCMA Policy Deviations in Hospital Practice

Mulac, A., Mathiesen, L., Taxis, K., & Granas, A. G. (2021). Barcode medication administration technology use in hospital practice: A mixed-methods observational study of policy deviations. *BMJ Quality & Safety, 30*(12), 1021-1030. https://doi.org/10.1136/bmjqs-2021-013223

What this resource provides. This mixed-methods observational study examines how barcode medication administration is actually used and where practice deviates from policy. Its value is the combination of observed work and analysis of why deviations occur. It shows that installing BCMA does not automatically create a closed-loop process if staff encounter barriers or normalize workarounds.

Why it matters for the improvement plan. The study is directly relevant to the fictional event because the scanner failure and manual override removed the electronic patient-medication match. It supports measuring bedside scanning, observing workflow, and examining the reasons behind overrides rather than treating every deviation as the same behavior. It also supports designing the downtime process with the nurses who use it.

How and when nurses should use it. Use this study during workflow mapping, PDSA planning, and interpretation of scan-compliance data. Educators can use examples of policy deviation in discussion, while quality staff can use the methods to conduct short observational audits. The source is particularly useful when compliance is lower than expected and the team needs to know whether the cause is equipment, workflow, knowledge, alert burden, or deliberate bypass.

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5. Grailey et al. - Facilitators and Barriers to BCMA

Grailey, K., Hussain, R., Wylleman, E., Ezzat, A., Huf, S., & Franklin, B. D. (2023). Understanding the facilitators and barriers to barcode medication administration by nursing staff using behavioural science frameworks: A mixed methods study. *BMC Nursing, 22*, 378. https://doi.org/10.1186/s12912-023-01382-x

What this resource provides. This mixed-methods study uses behavioral science frameworks to identify factors that help or hinder nursing use of BCMA. It considers capability, opportunity, motivation, and the surrounding work system. The source is useful because it moves beyond a simple compliant/noncompliant label and explains why practice changes succeed or fail.

Why it matters for the improvement plan. The bundle requires reliable devices, accessible training, leadership support, and a workflow that makes safe behavior practical. Grailey et al. help the team anticipate barriers such as insufficient equipment, time pressure, unclear expectations, and weak feedback. The study supports combining technical repair with education and environmental change.

How and when nurses should use it. Nurse educators and implementation leaders should use this resource when designing staff interviews, barrier surveys, and pilot modifications. During the first two weeks, the team can organize feedback under capability, opportunity, and motivation. Use the findings to choose an intervention that matches the cause: training for a knowledge gap, equipment for an opportunity gap, or feedback and role modeling for a motivation gap.

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6. Soorma et al. - Increasing BCMA in an Emergency Department

Soorma, K., O'Neill, A., Ramsay, A., Toth, A., Weisburd, S., Rivera, S., & Tejada, C. (2024). Increasing barcode medication administration in the emergency department setting. *Practical Implementation of Nursing Science, 3*(2), 35-36. https://doi.org/10.29024/pins.84

What this resource provides. This implementation report describes a practical nursing-science project aimed at increasing BCMA use in a complex acute-care environment. Although the setting differs from a medical-surgical unit, it offers a concise example of translating a safety target into workflow change, staff engagement, and measurement.

Why it matters for the improvement plan. The improvement plan needs a realistic implementation model, not only evidence that scanning is beneficial. This source supports piloting, using frontline feedback, tracking adherence, and adapting the process to a high-interruption environment. It also helps demonstrate that BCMA improvement is a nursing practice issue as well as an information-technology issue.

How and when nurses should use it. Use this resource when designing the pilot timeline, selecting process measures, and coaching super-users. It is especially useful for the nurse manager and unit council because it illustrates how to organize a practice change in a busy environment. Because it is a brief implementation report, pair it with larger studies and standards when making policy-level decisions.

Category 3: Human Factors, Interruptions, and Learning Culture

7. Alteren et al. - Nurses Managing Medication Interruptions

Alteren, J., Hermstad, M., Nerdal, L., & Jordan, S. (2021). Working in a minefield: Nurses' strategies for handling medicine administration interruptions in hospitals: A qualitative interview study. *BMC Health Services Research, 21*, 1094. https://doi.org/10.1186/s12913-021-07122-8

What this resource provides. This qualitative interview study explores how nurses experience and manage interruptions during medication administration. It describes the competing demands and informal strategies nurses use to protect attention. Qualitative evidence is valuable here because interruption risk is strongly shaped by context, teamwork, and how work is organized.

Why it matters for the improvement plan. The fictional incident included a phone call and non-urgent alarm during insulin administration. This resource supports a protected medication process that distinguishes urgent from non-urgent interruptions and teaches a safe restart. It also warns against an unrealistic no interruptions rule, which could conflict with urgent patient needs.

How and when nurses should use it. Use the study when the unit council designs the interruption cue, coverage process, and simulation. Ask nurses which interruptions can be redirected, which require immediate response, and what helps them resume safely. The resource is also useful during debriefing because it validates staff experience while keeping the focus on redesign. Pair it with direct unit observation to identify local interruption patterns.

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8. Schroers et al. - Nurses' Perceived Causes of Medication Administration Errors

Schroers, G., Ross, J. G., & Moriarty, H. (2021). Nurses' perceived causes of medication administration errors: A qualitative systematic review. *The Joint Commission Journal on Quality and Patient Safety, 47*(1), 38-53. https://doi.org/10.1016/j.jcjq.2020.09.010

What this resource provides. This qualitative systematic review synthesizes nurses' perceptions of factors that contribute to medication administration errors. Reported factors include workload, distractions, communication, knowledge, staffing, technology, and organizational conditions. A systematic review provides a broader evidence base than one local interview study.

Why it matters for the improvement plan. The root-cause analysis identified the same interacting domains. The review supports a systems explanation and helps prevent the organization from reducing the event to individual carelessness. It also supports collecting frontline nursing input because nurses can identify latent workflow risks before they appear in formal event data.

How and when nurses should use it. Quality staff and nurse leaders should use this source during root-cause meetings, staff listening sessions, and policy review. It can help create interview prompts and fishbone

categories. Educators can use it to explain why the bundle includes equipment, communication, interruption control, competency, and leadership feedback. It is not a substitute for investigating the actual event, so local evidence must remain central.

9. Fathizadeh et al. - Medication Error Prevalence and Related Factors

Fathizadeh, H., Mousavi, S.-S., Gharibi, Z., Rezaeipour, H., & Biojmajd, A.-R. (2024). Prevalence of medication errors and its related factors in Iranian nurses: An updated systematic review and meta-analysis. *BMC Nursing, 23*, 175. https://doi.org/10.1186/s12912-024-01836-w

What this resource provides. This updated systematic review and meta-analysis estimates medication-error prevalence and examines related nursing factors across included studies. It offers current quantitative evidence that medication errors are not rare isolated events and that working conditions, experience, and system factors matter.

Why it matters for the improvement plan. The source strengthens the case for proactive prevention and continued monitoring. It supports the plan's decision to track both actual harm and near misses, because waiting for a catastrophic event underestimates risk. It also supports attention to workload, training, and clinical environment rather than relying on reminders.

How and when nurses should use it. Use this resource in leadership and education materials to explain why sustained surveillance is necessary. Quality staff can use it when defending a dashboard that includes near misses and process measures. Because prevalence estimates depend on setting, definitions, and reporting methods, do not use one pooled number as the unit's baseline. Use local validated data for targets and use the review to frame the broader problem.

Category 4: Education, Teamwork, Implementation, and Sustainability

10. Jaam et al. - Pharmacist-Led Education to Reduce Medication Errors

Jaam, M., Naseralallah, L. M., Hussain, T. A., & Pawluk, S. A. (2021). Pharmacist-led educational interventions provided to healthcare providers to reduce medication errors: A systematic review and meta-analysis. *PLOS ONE, 16*(6), e0253588. https://doi.org/10.1371/journal.pone.0253588

What this resource provides. This systematic review and meta-analysis evaluates pharmacist-led educational interventions for healthcare providers. It found an association between pharmacist education and reduced medication errors across included studies. The review supports education that is medication-specific, interdisciplinary, and connected to practice.

Why it matters for the improvement plan. The bundle includes pharmacist-led instruction on insulin products, dose context, hypoglycemia, storage, and override risks. The source supports using pharmacists as active educators instead of limiting their role to post-event review. It also supports combining education with workflow change rather than assuming a policy memo is sufficient.

How and when nurses should use it. Use this source when designing the in-service, competency content, and pharmacist staffing request. The pharmacist can lead the medication-specific sections, review difficult orders, and help analyze trends after implementation. Education should include demonstration and simulation and should be repeated for new, float, and agency staff. Track competency and outcomes because education effectiveness depends on implementation quality.

11. Grimes and Guinan - Interprofessional Medication-Safety Education

Grimes, T. C., & Guinan, E. M. (2023). Interprofessional education focused on medication safety: A systematic review. *Journal of Interprofessional Care, 37*(1), 131-149. https://doi.org/10.1080/13561820.2021.2015301

What this resource provides. This systematic review examines interprofessional education focused on medication safety. It emphasizes learning that brings professions together around shared roles, communication, and safe medication processes. The source is useful because medication administration errors cross nursing, pharmacy, medicine, technology, and organizational boundaries.

Why it matters for the improvement plan. The improvement plan assigns connected responsibilities to bedside nurses, charge nurses, pharmacists, providers, educators, IT, and quality staff. Interprofessional education allows the team to practice escalation and clarify ownership. It prevents the common problem in which each department understands only its own task and unsafe gaps remain between tasks.

How and when nurses should use it. Use this review when planning the in-service audience and simulation roles. Include pharmacy and IT in the scanner-failure scenario, and ask leaders to practice the escalation pathway. The resource is especially useful during orientation redesign and annual competency. It can also guide debrief questions about communication and handoffs. Combine it with profession-specific skill checks so shared learning does not replace individual competency.

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12. Kim et al. - Prioritizing Medication-Error Prevention Strategies

Kim, S., Kim, H., & Suh, H. S. (2022). Priorities in the prevention strategies for medication error using the analytical hierarchy process method. *Healthcare, 10*(3), 512. https://doi.org/10.3390/healthcare10030512

What this resource provides. This study applies the analytical hierarchy process to prioritize medication-error prevention strategies. It offers a structured way to compare interventions when time and resources are limited. The source is valuable for implementation because organizations often know many possible solutions but need a transparent method to decide what to do first.

Why it matters for the improvement plan. The insulin safety plan includes equipment repair, BCMA workflow, independent checks, interruption control, education, and measurement. This resource supports ranking changes by expected safety effect, feasibility, urgency, and resource demand rather than choosing the most visible or easiest action. It can help leadership justify why reliable scanner access and a safe downtime process should be addressed before adding more reminders.

How and when nurses should use it. Use the prioritization approach during the initial improvement-team meeting and after each PDSA cycle. Ask stakeholders to score proposed changes against agreed criteria. Revisit the ranking when data show a new barrier. The method is most useful as a decision aid, not as proof that one strategy will work in every unit. Decisions should still incorporate local event data, patient needs, and current standards.

Implementation Quick-Start Guide

The resources become useful when they are connected to decisions. The following sequence shows how an implementation team can use the tool kit during a 90-day pilot.

Stage	Key decision	Primary tool-kit resources	Output
1. Define and authorize	Why is change necessary, and which high-alert expectations apply?	WHO, ISMP, Joint Commission	Approved aim, scope, policy gap list
2. Map current work	Where do scanning, overrides, interruptions, and handoffs fail?	Mulac; Grailey; Alteren; Schroers	Current-state map and root-cause summary
3. Design the bundle	Which safeguards address the identified causes without unnecessary burden?	ISMP; BCMA sources; Kim	Pilot workflow, downtime card, roles
4. Prepare people	What must staff know and demonstrate?	Jaam; Grimes and Guinan	In-service, simulation, competency checklist
5. Test and learn	Is the bundle used, effective, and workable?	All categories plus local data	PDSA findings, revised workflow, run charts
6. Sustain	How will the organization prevent drift?	Standards, education, prioritization sources	Orientation, audit schedule, escalation triggers

Recommended Local Tools to Build

- **One-page downtime card:** pause, charge-nurse notification, spare-device route, independent verification, documentation, and report steps.
- **Competency checklist:** one-patient preparation, two identifiers, scan sequence, clinical verification, interruption restart, patient explanation, and exception handling.
- **Audit form:** full scan, override reason, eligible double check, observed interruption, and immediate coaching.
- **Dashboard:** process, outcome, and balancing measures displayed over time.
- **Staff feedback form:** confidence rating, equipment barrier, workflow burden, second-check availability, and recommended change.
- **Patient teaching card:** insulin purpose, hypoglycemia symptoms, and invitation to ask questions.

Evaluation of Usefulness and Sustainability

The tool kit is useful because it combines policy authority, direct BCMA evidence, nursing human-factors research, and implementation guidance. No single source is asked to answer every question. Standards define expectations, research explains risk and intervention mechanisms, and implementation studies help the team design workable change. The annotations also state limitations, such as setting differences and the need for local validation.

Sustainability depends on integrating the evidence into ordinary work. The unit should not leave these sources in a folder after the presentation. The key requirements should appear in orientation, annual competency, the insulin policy, the scanner maintenance process, and the dashboard review. A named medication-safety owner should review the links annually and replace outdated standards. Staff should be able to access the downtime card and competency checklist at the point of care without reading full articles during a medication pass.

Distinguished-Criteria Alignment

Expected performance area	Evidence in this tool kit
At least 12 relevant resources	Twelve current scholarly and professional resources are organized into four implementation categories.
Credible APA citations and links	Each annotation begins with a full APA-style citation and working DOI or organizational URL.
Description and value	Each source is evaluated for evidence type, credibility, relevance, strengths, and setting limitations.
How nurses use the resource	Every entry specifies users, implementation stage, and concrete use in education, policy, workflow, measurement, or sustainment.
Professional organization	Category structure, quick-start guide, local tool list, and sustainability plan make the file usable rather than merely descriptive.

Maintenance note. Review the standards and all links before publication and at least annually. Replace superseded guidance, verify access, and document the review date. The resource list supports academic and implementation planning; it does not replace an organization's approved policy or clinical judgment.