**\*\*\*\*\*\* All answers to each number must come from the provided textbook’s corresponding chapter and be at least 3-5 sentences long \*\*\*\*\*\***

**Each number must be thoroughly answered from each of the 4, 7-11 page corresponding short chapter’s information (8 questions).**

**Textbook Provided. Use your own words. No Direct Quotes. Turnitin Used. References for each chapter listed below.**

**Use additional sources listed below where more information is needed.**

**Cite all Information.**

**APA 7 format: Times New Roman, 12. Double spacing between lines, no extra spacing between paragraphs. \*Regular spacing between words\* 1” margins. MS Word doc.**

**Chapter 29**

1. **Explain why healthcare providers are susceptible to fatigue.**
2. **What element does the Joint Commission determine is the foundation of raising awareness and thereby reducing fatigue in the workplace? Describe the attributes of this element.**

**Chapter 30**

1. **Compare and contrast effective and poor communication.**
2. **Explain how the use of technology can resolve failures of communication.**

**Chapter 31**

1. **Explain how to create a culture of communication.**
2. **Describe the function of Synopsis.**

**Chapter 32**

1. **Explain the risks and benefits of e-mail communication.**
2. **Explain the importance of educating patients on the risk of using e-mail.**

**References**

Alvarez, D. L., & Youngberg, B. J. (2011). The impact of fatigue on error and patient safety. In B.J. Youngberg (Ed.), *Principles of risk management and patient safety* (pp. 423-430). Jones & Bartlett Learning.

DeVito, S. (2011). Managing the failures of communication in healthcare settings. In B.J. Youngberg (Ed.), *Principles of risk management and patient safety* (pp. 431-442). Jones & Bartlett Learning.

Greening, S.. (2011). The risks and benefits of using e-mail to facilitate communication between providers and patients. In B.J. Youngberg (Ed.), *Principles of risk management and patient safety* (pp. 455-462). Jones & Bartlett Learning.

Westendorp-Holland, J., & Youngberg, B. J. (2011). Improving handoff procedures in health care to reduce risk and promote safety. In B.J. Youngberg (Ed.), *Principles of risk management and patient safety* (pp. 443-452). Jones & Bartlett Learning.

**Possible Sources**

The Pros And Cons To Working "Only" 3 Days A Week

<https://nurse.org/articles/nurses-three-days-a-week/>

Austin, S. (2008). 7 legal tips for safe nursing practice. *Nursing 2008, March,* 34-39.

<https://journals.lww.com/nursing/fulltext/2008/03000/seven_legal_tips_for_safe_nursing_practice.36.aspx>

The criminalization of mistakes in nursing <https://www.sciencedirect.com/science/article/abs/pii/S1555415511003400>

Talking about harmful medical errors with patients <http://depts.washington.edu/toolbox/errors.html>

American Society for Health Care Risk Management, Strategic Plan <https://www.ashrm.org/about/governance/2019-2021-strategic%20plan>

American Health Information Management Association <http://www.ahima.org/>

Agency for Healthcare Research and Quality <https://www.ahrq.gov/>

AHRQ Patient Safety Network <https://psnet.ahrq.gov/>

AHRQ Innovations Exchange <https://innovations.ahrq.gov/>

CMS, Regulations and Guidance <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research-Statistics-Data-and-Systems>

CMS, Innovations <https://innovation.cms.gov/>

VA HSR&D COINS <https://www.hsrd.research.va.gov/centers/>

NIH Medline Plus <https://medlineplus.gov/patientsafety.html>