Be Proactive, Attentive & Ask While Not Sure

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"Patient safety" is the foundation of medical quality and the most basic common goal between medical care providers and patients. For the safety of patients, each hospital has developed a set of standard operating procedures and notification systems. It has been 8 years since I entered the workplace. I have also been notified of several medical safety incidents, most of which occurred when I was a new recruit.

Let Go of Myself to Develop My Profession

I remember the moment when a patient safety incident happened; I was in fear worrying if the patient was endangered because of my mistakes. I worried if I would become a problematic person in the mind of the supervisors? However, because of this incident, I have been more careful in caring for patients in the future.

Once I saw that there was a problem with the dosage on the physician's order. I immediately contacted the doctor who then immediately adjusted the dosage to prevent a patient safety incident. This made me feel more confident. With the accumulation of experience, the number of patient safety incidents decreased.

When patient safety incidents happened, most people would feel that they are really unlucky. Why did it happen during my shift? Sometimes one may also feel angry, because often the caregiver repeatedly chose to be noncompliant especially after considerable education regarding safety. Why did the patients still not listen? In addition, from experience, most incidents occur during the night shift as a result of staff shortage,

and when the caregivers are off. Despite nurses making hourly rounds, accidents often happen during the intervals. Then I have to tell a supervisor and file an incident report.

Clinically, dislodging of the nasogastric tube is very common in the ward, mostly because the adhesive is not strong enough or the method of application is inappropriate. Improper application method can cause inflammatory patient's nasal mucosa. In addition, when a confused patient pulls the nasogastric tube, staff has to reinsert causing more discomfort. Therefore, the nursing staff needs to make improvement to prevent nasal mucosal pressure and slippage. In addition to the development of standard care procedures, strengthening the caregiver's health education has also put aside the old concepts and researched a better way to make the nasogastric tube more secure and effectively reduce the occurrence of nasal mucosal pressure.

Effective Communication at Shift Change to Reduce Errors

One morning, I heard the doctor asking the nursing staff during the rounds: "What is the amount of intravenous delivery for this patient yesterday? Why doesn't it match the total amount? Isn't it clear that the doctor ordered it? Why didn't people ask? Who

is involved during the shift change? This is too much! I need to file an incident report." The nursing-in-charge looked terrified and was a little overwhelmed while apologizing to the doctor, saying that it was because of communication errors during the shift change. This is the most memorable and discussed event among the recent medical safety incidents.

As a result of the nurses not knowing the doctor's order and a failure in communication during shift change, the IV quantity was incorrect. Through this incident, the nursing-in-charge discussed the issues in the morning meeting and at the ward meeting, clarified the doctor's order, and also took the opportunity to educate the nursing staff to improve medical care quality as well as effective communication.

Prevent Patients' Falling Accidents

At present, most of the wards contain oncology and gastroenterology patients. Most of the patients need analgesics for pain management, but its side effects increase the chance of falling accident. "Nurse, my dad is in pain now. Can you help relieve his pain?" "Nurse, my dad is more comfortable after the sedation and resting in bed now. I am leaving now; I have to go to work tomorrow. Please watch him carefully. Thank you." Oncology patients often use morphine-based analgesics, which include side

effects such as nausea, vomiting, and sleepiness. Many patients, who use painkillers that are not accompanied by their families, have higher chances of accidental falling.

Once because of the fall, a patient suffered a hand fracture. The anxious fresh colleague worried about the patient's condition and whether the family would blame them for not doing a good job in health education. Her mood was affected all day and cried in the staff room, remorseful. For the new graduate, this was a big setback.

Among the patients I cared for, there were situations where there were no family members present. When caring for such patients, I will treat the patients as my own family members. After all, being sick and alone in the hospital without family must be lonesome! If the patients want to drink water or go to the bathroom, I will spare some time to assist them. However, there was one time where I just left the ward, and everyone ran to the hallway after hearing a loud bang. It turned out that the elderly patient wanted to fill the water container and was embarrassed to trouble us so he walked out by himself. However, he was weak and fell to the ground. I could not blame him at the moment, so I quickly dealt with his wounds; calmed his emotions; and told him: "When you need us, you can call us anytime. Don't be embarrassed." The patient said anxiously, "I'm sorry for causing you trouble."

If my response was: "Didn't I tell you not to leave the bed yourself? Why didn't you listen?" It may cause the patient to be more emotional and turn remorse into anger. Nursing is about love and care. If we change our thinking and care more about others, I think patients will be more cooperative.

Learn from Errors

If a patient does not have family caregiver, we need to increase monitoring visits. If no caretaker is available the ward should be equipped with out-of-bed warning devices. Using the out-of-bed warning device can let the nursing staff know if the patient is about to get out of bed and can provide timely assistance to reduce the accidental falls.

Based on years of experience of caring for patients, filing incident reports is tantamount to "learning from errors", learning and growing from practice. "Proactive" and "careful" can effectively prevent the occurrence of safety incidents. When other staff has safety incidents, we must vigilant so similar incidents won't happen under our watch. When in doubt, ask for help, even if reprimanded, the surrounding nurses may become our mentors. Colleagues learn from each other, remind each other, and work together to create a safe and comfortable medical environment, which is also the main purpose of incident notification - keeping patients safe.