Enhancing Nursing Quality Secures Patient Safety

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The safety of the patients is the most important task in the hospital. However, everyone makes mistakes. In the past, the health care managers handled the mistakes or "near miss" incidents by means of "punishment." It puts health workers in a condemning work environment all the time. This has made their work more stressful. In recent years, the health industry has continuously improved through training, and creating safer work environments, as well as by encouraging the reporting of unusual incidents, patients are able to receive safer care and health workers can reduce their workload, enhance their resilience, and remain in their jobs.

The development of culture for patient safety is the same as enhancing nursing quality. It requires coordination in various areas. Effective communication, work training and continuing education, discussion and feedback for warning incidents, monitoring potential trend and model, and establishing a safe environment with supervisory support are some examples. The proactive approach adopted by Hualien Tzu Chi Hospital includes visual indicators management, work training and an early warning system for incidents.

Implementing Indicator Management by Applying Visual Graphics

In order to compare nursing-quality index among different units, a quality indicator approach using red and green light is adopted in each unit starting in January 2020. It was the result of joint discussions between the Nursing department and the Nursing Quality Committee. The method uses a green light to indicate the best quality. By means of bubble charts, supervisors of each unit can easily visualize their unit's standing as compared with other units in the hospital.

At the beginning, everyone felt strange with the display. Some people reacted adversely. However, through various explanations, communications, healthy competition

between units and encouraging improvements, colleagues and supervisors have given those changes with some feedbacks, as follow:

"Colleagues can feel the changes when seeing the quality indicators of the unit gradually becoming stable."

"Colleagues are sharing information to enhance nursing quality."

"At the beginning, we just hoped not to be the last one in line, now everyone is working together towards improving care quality."

Learn from Adverse Events

Adverse events hurt patients and negatively impact the medical team. Some colleagues failed to report the events due to fear of condemnation. Fortunately, after many years' efforts from the hospital, the medical team now is able to face adverse events with positive feedback. In order for more people to avoid similar incidents by sharing information, the hospital is using warning incident notice to remind people, including reminders of some common patient safety incidents, caring for wounds and skin, etc.

The feedback from a colleague nurse: "These situations are often encountered during clinical practices. Through a reminder from the 'Warning incident notice', I react more carefully when I am facing a similar situation. Mistakes indeed hide in small things." There was also a chief nurse sharing her experience, "Before, our colleagues did not like to see the Hospital Information System bulletin. Lately, they would actively click on the link to visit the bulletin, and during the morning meeting, we also discuss how to handle similar situations."

Evidence-Based Nursing and Training - Growing Together

Besides learning from the adverse events, we also integrated the procedures of evidence-based nursing to improve each other. The class of evidence-based nursing started in early 2020, clinical teachers led colleagues who have less experience started looking for common care problems inside the unit; and use Q&A to find supporting documents. After sorting through all the documents and suggestions, we turn them into easily understandable information or update health-care tools for the patients. The findings are published so knowledge is shared.

Every season's "Evidence-Based New Knowledge" meeting also drives people to learn together. Along with current events, the meeting results in learning new knowledge by reviewing the past events. For example, at the beginning of 2020 when the COVID-19 epidemic condition was relatively unclear, colleagues who cared for the

suspected or confirmed patients were emotionally affected. The first-line colleagues later were able to feel safer during clinical care after checking out relevant information; discussing with Infection Control unit about how to reduce infection risks, such as: the wearing of Personal Protective Equipment, cleaning environment, adjusting care procedure, increasing knowledge of covid-19 and preparing medical supplies, etc.

Besides training to increase knowledge we regularly monitor quality indicators to reassure the accuracy of execution. At the same time, we also benchmark with other units to enhance care quality of other units - taking proactive action and finding each unit's own health care's "shining spots."

Studying the topic of fall prevention, the team of gynecology and obstetrics found most newborn mothers were in a good health condition when admitted. However, after giving birth, their focuses changed to the newborns and learning related caring skills. There were many falling incidents when the mothers were caught off-guard trying to get

in-and-out of the bed. The introduction of patient-participation modelling has increased attention of the mothers and nurses in fall prevention. The using of "maternity/nurse fall risk factor evaluation chart" and education and training have successfully eliminated the fall rate from 0.28% to 0%. The evaluation system later was promoted to medical and surgical wards. Patients' families also reacted positively to the system.

The chief nurse of maternity ward, Lin Jiahue, said that at the beginning of the project, all the nurses were complaining. The mother and her family members also thought such precaution were unnecessary. However, later on, they all realized that the mothers were at risks of falling, especially during the moment to standup after using the toilet. Gradually more and more mothers gave positive feedback to the nurses. They think the nurses are very professional, providing them with good reminders and their attitudes are very nice too. The chief nurse also took the meeting as a chance to publicly praise the nurses. At the end, the nurses felt a sense of achievement. This project also passed the Taiwan Nurses Association's administrative review.

Nobody likes to leave their comfort zone for changes. However, through training, visual management, and benchmarking, one motivates to become better. This will also strengthen one's resilience to grow together with the team. This creates a positive environment and enhances care quality so all the patients are safe.