Rapid Improvement Project on Patient Care Process
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Introduction
Patient safety round (PSR) has been identified as an effective tool to enhance patient safety culture. PSR conducted by Ruttonjee & Tang Shiu Kin Hospitals Nursing Services Division (NSD) was implemented since 2009. Previously, the PSR focused more on environmental scan. To step forward, patient tracer approach was introduced in May 2014. Rounding team proactively followed patient’s experience of care, treatment, or services through nursing care delivery process.

Objectives
1. To demonstrate nursing management’s commitment to quality and safety. 2. To identify, acknowledge and share good practice. 3. To identify, prevent and mitigate patient/staff harm. 4. To increase staff engagement and promulgate open communication.

Methodology
To initiate changes for patient care process, we adopted John Kotter’s change management model to guide the improvement project. The change comprised of eight stages including three phases. The first phase was “creating a climate for change” – PSR via patient tracer approach was conducted to establish the sense of urgency for improvement; nurse experts were engaged as guiding team to mobilize change; clear vision and strategies on specific theme were developed after PSR. The second phase was “engaging and enabling the organization” – the strategies created was shared and communicated with all nurses through meetings and seminars. Nurse experts and frontline staff were empowered to work together to improve patient care process. Short-term wins were created as staff awareness and expert’s commitment were accelerated. Final phase was “implementing and sustaining the change” – to consolidate gains and anchor new PSR approach, different patient care process will
be reviewed.

Result
The reframed PSR had been implemented for 8 months. The pilot theme on “diabetes care management” was completed in Sept 2014. Four wards from different clinical department were inspected. Team nurse and ward manager were engaged in reviewing care and system management. Six good practices were identified. Eight areas for improvement were recommended to clinical departments, five areas recommended to Diabetes Nursing Team and one area recommended to nursing management. To anchor new approach, coming theme on “falls prevention and management” was identified to be reviewed. Conclusions: Through open communication, staff engagement and risk identification, nurses can have better understanding on how the design of systems, processes, workflows, equipment and environment best facilitate the delivery of safe patient care.