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Analysis and Countermeasures on 195 Cases of Adverse Events in Nursing Care

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ABSTRACT **Objective:** To develop preventive measures, improve the quality of nursing, and ensure the safety of patients by analyzing the causes and characteristics of adverse events in nursing care. **Methods:** Retrospectively analyzing 195 cases of adverse events in nursing care which occurred in the hospital between January 2014 and December 2014 to study the classifications, causes and duration of adverse events in nursing care and their association with the nurses' different work experiences and titles. **Results:** The Top 3 of the adverse events in nursing care are respectively: 52 cases of wrong pills, which account for 26.7%; 30 cases of missing treatment, checking and nursing, which account for 15.4%; 23 cases of hospital pressure ulcer, which account for 11.8%. The main causes was due to the enforcement of the system is not done strictly, safety management is not in place and clinical teaching is not rigorous. Day shifts mark the peak of adverse events in nursing care, and the nurses' working experiences and titles are related to the occurrence of the adverse events in nursing care. **Conclusion:** All the core systems and rules should be enforced rigorously in clinical nursing, strengthen the monitoring of the key group, enforce the adverse events reporting system, and improve professional training of the young nurses to reduce the occurrence of adverse events in nursing care. Nursing managers should analyze the factors to develop preventive measures, strengthen nursing safety management, and enhance the quality as well as the level of nursing service in the process of quality management and improvement.

KEYWORDS

Adverse nursing events

Cause analysis

Countermeasures

1. Introduction

Adverse events in nursing care refers to the unplanned, unpredicted or usually undesired events that occur in the process of nursing, including falling, wrong pills, missing, wrong inhaling or asphyxia, scalding and other nursing accidents that are unusual and related to the patients' safety. In order to enhance the safety awareness and risk management of nursing staff, it is encouraged that nursing staff should report adverse nursing events actively, reduce the occurrence of nursing defects and treat nursing defects scientifically and reasonably. Hence, we make a retrospective study on these events which occurred between January and December 2014 in the hospital. These will help analyze the causes and characteristics of adverse events, and investigate effective management measures for reducing adverse events, then enhancing patients' safety [1,2].

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2. General materials

(1) Analysis and discussion on the adverse nursing events which occurred between January and December 2014 in the hospital. The types of the nursing adverse events, see Table 1.

(2) The relationship between the occurrence of adverse events and time. See Table 2.

(3) The distribution of the titles of 96 nurses involved in adverse events.

(4) The distribution of working experiences of 96 nurses involved in adverse events.

3. Subjects and methods

The subjects were 195 adverse events which occurred in

Table 1. The types of adverse nursing events.

Type	Number	Percentage (%)
Wrong Pills	52	26.7
Identification of Patients	10	5.1
Pressure Ulcer	23	11.8
Pipe Slippage/Unplanned Extubation	3	1.5
Falling/Falling off the Bed	9	4.6
Specimen Error	17	8.7
Wrong Operation	2	1
Transfusion Swelling	13	6.7
Scald	1	0.5
Missing	30	15.4
Pathological Fracture	1	0.5
Withdrawal of Needles in Advance	4	2.1
Others	30	15.4
Total	195	100

Table 2. The relationship between the occurrence of adverse events andtime.

Time	8:00-18:00	18:00-24:00	24:00-8:00
Number	96	62	37
Percentage	49.2%	31.8%	19%

Table 3. The relationship between the occurrence of adverse events and titles.

Title	Nurses	Primary Nurse	Nurse-in-Charge
Number	77	15	4
Percentage	80.2%	15.6%	4.2%

Table 4. The relationship between adverse events and working experiences.

Working experiences	Below 2 Years	2-5 Years	Above 5 Years
Number	59	33	4
Percentage	61.4%	34.4%	4.2%

the hospital between January and December 2014. This study adopted the method of retrospective research, and analyzed the adverse events reported by the nursing departments retrospectively.

4. Analysis

4.1. The analysis of adverse nursing events

As observed from Table 1, wrong pills are 52 cases, which account for 26.7%, ranked the first in adverse nursing events. Missing of treatments, checking and nursing are 30 cases, which account for 15.4%, ranked second. The occurrences of pressure ulcer are 23 cases, which account for 11.8%, ranked third.

As observed from Table 2, through the analysis of the periods and shifts that the nursing adverse events occurred, occurrence rate of the adverse nursing events in the day shift (8:00-18:00) is higher than that of the night shift (18:00-8:00), and occurrence rate of the night shift (18:00-24:00) is significantly higher than that of the late night shift (24:00-8:00). Patients' treatments and nursing care mainly take place in the daytime, which the nursing workload was large, and due to the working process was also complex, so the occurrence rate of adverse events was high.

As Table 4 shows, the younger the nurses, the higher the occurrence rate of adverse nursing events. First, young nurses lacked professional knowledge, and they were unable to make correct judgements or gave timely treatments to some clinical problems. Second, young nurses' operational skills were poor, and they had lesser clinical experiences, as they do not knew the key points of nursing and the observing of special illnesses, so that they were made some mistakes that could be avoided. Third, communication skills of young nurses were poor, and incapable in making good explanations [3-5].

5. Countermeasures

5.1. Countermeasures encompass strict enforcement of the core nursing system, the improvement of all the operational processes

Every system and rule is written with a lot of blood, sweat and tears, so the effective enforcement of the systems and rules is the guarantee of all the protective measures. As some surveys indicated that the non-enforcement of nursing systems and practices ranked were top 1 in the causes of the occurrence of adverse events in nursing care. Focus on strengthening the implementation of the core system, and emphasize the implementation of the system of pills-distribution, checking, shifting, nursing classification, as well as thorough examination of all departments and on-site sampling to keep abreast of the implementation of the core system, which ensures that nursing staff really master the essential of the core system, and to operate as required, in reducing the occurrences of adverse events.

5.2 Strengthen the monitoring of key groups

Focus on the monitoring of young nurses, low level nurses, including the monitoring of critical period, key patients, and key nursing operations. Deliver both explanations, and follow-ups with attention. Conduct supervision, checking and monitoring on the new patients, transferred patients, severely sick patients, and patients who have potential risks of medical tangles as priority [6].

5.3 Strict reporting system of nursing adverse events

Classify the nursing adverse events into Grade I, Grade II, Grade III and Grade IV according to 2008 "Medical Safety (Nursing Adverse) Events Reporting System", established by China Hospital Association that is authorized by the Department of Health Administration of the Ministry of

Health. When the nurses in charge encounter the Grade I and II events, they should immediately report the events to the head nurse, and take respective measures to minimize the damages. At the same time, they should report orally the events to the nursing departments and related authorities. Within the departments, the nursing staff should fill the "Nursing Adverse Events Report" within 24 hours, and submit to the nursing department after signature. The time limit of major events is no more than six hours; the nursing department should make investigation and verification immediately after the rescue or emergency treatments are over. As for Grade III and IV events, the reporters should fill the "Nursing Adverse Events Report Form" or "Nursing Defects Correction Report Form" in three working days, and submit to the nursing department [7].

5.4. Nurses' standardized training

Strengthen the professional training of young nurses, improve the content of the nurses' standardized training, train the nursing staff according to nurses' standardized training program, and conduct strict examination on basic theory and operational skills. Intensify learning awareness, enhance the level of basic theory and operational skills. Organize skills training courses according to the post requirements, the courses should be planned, targeted, and detailed, for example, emergency nursing skills, pipe care skills, nursing record writing and critically ill patients observing skills and etc., to improve nurses' skills [8].

The cause of every adverse events are not isolated, that is because there is an error of a certain link in the overall process which results in chain reaction. Adverse nursing events usually occur inadvertently, and the nursing staff should analyze the occurrence earnestly, accumulate the experiences and prevent the recurrence, while the nursing managers should find the reasons from systematically, rather than simply punish and lay the blame.

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