NURSING DIGEST

Official Newsletter - Association Of Nurse Executives (India)

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INSIDE

ANEICON 2024
ASSOCIATION OF NURSE EXECUTIVES (INDIA)
PASSION TO ACTION

Save the Date

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WHERE NURSING MEETS NURSES

Message from the President

Capt Ajitha Nair
President, ANEI

Dear ANEI Family members,

Upon completing one year in office in January of 2024, I would like to express my sincere gratitude for your wholehearted support in making ANEI a meaningful association for nurses and patients. In 2023, we had a superb national conference at Hyderabad and a successful ongoing monthly Empower Hour and Patient Safety Fellowship program. Besides, we could successfully educate over 6000 nursing students in person on NPSGs and are still counting. Also, I could actively participate in the Health and Environment Safety Platform (HELP) of PHFI, and many more successful activities are ongoing. It's commendable that we have over 700 paid members now, and we aim to double our membership strength this year.

As the new year 2024 dawned, we are gearing up for our annual flagship event, ANEICON 2024, in Chennai on 24-25th May. I would plead all our esteemed members to make advance plans to attend the conference from which you will derive immense mileage not only in terms of advancing your leadership skills but umpteen opportunities for networking and socializing, which is essential for your career and personality growth. There are many meticulously planned national-level competitions as part of the conference, and make sure that your organization is represented well in each of them. ANEI members get attractive discounts and use this opportunity to encourage your friends and colleagues to become members of our association. In addition, you can use our brochure (shortly expected) and conference slides to approach and impress upon your top management, doctors, and other healthcare colleagues to sponsor you and, even better, to make them participate in the conference. Through this message, I would personally request all nurse leaders to come forward to participate in ANEICON2024 and, encourage your nurses to participate in competitions and send them to the conference. Please negotiate and impress your top leaders for conference sponsorship and participation in whichever way possible.

This year's theme, **"Transformational Leadership: Impacting Healthcare Today and Roadmap for the Future,"** resonates deeply with the essence of our collective mission. At the heart of this theme lies the recognition of nurses' pivotal role in shaping the trajectory of healthcare delivery at present and in the future. As the backbone of our healthcare system, nurses are not just caregivers but innovators, patient advocates, and leaders. Their tireless dedication and unwavering commitment to patient-centered care are the cornerstone of our profession.

However, realizing our vision for the future of healthcare relies heavily on the shoulders of healthcare leaders, particularly nurse leaders. Our responsibility is to create an environment that empowers nurses to thrive and excel in their roles. This entails providing them with the necessary resources, support, and professional growth and development opportunities. It also requires fostering a culture of collaboration, innovation, and continuous learning within our organizations.

As we embark on this journey towards transformational leadership, I call upon all healthcare organizations and their leaders to join hands in this endeavor to shape the future of our healthcare. Let us come together, not as competitors, but as collaborators united by a shared vision - to advance the quality, safety, and accessibility of healthcare for all human beings. By leveraging our collective knowledge, expertise, and resources, we can pave the way for a brighter, healthier future for future generations.

ANEICON 2024 presents a unique opportunity for us to engage in meaningful dialogue, exchange best practices, and chart a course for the future of healthcare. I encourage each of you to actively participate in the conference, share your insights and experiences, and be part of this transformative journey.

Let us lead the way towards a healthier and more equitable world. I am looking forward to seeing you in Chennai for ANEICON 2024.

Sincerely yours,
Ajitha

ASSOCIATION OF NURSE EXECUTIVES (INDIA)

Presents

4th Annual Flagship Event

ANEiCON 2024

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TRANSFORMATIONAL LEADERSHIP: IMPACTING HEALTHCARE TODAY AND ROADMAP FOR THE FUTURE

ASSOCIATION OF NURSE EXECUTIVES (India) | Founded in 2017 | Registered under the Societies Act XXI of 1860 | Registration No S/3362/SDM/NW/2018 on 31st December 2018

VENUE

Feathers Hotel

4, 129, Mount Poonamallee Road, Manapakkam, Chennai, Tamil Nadu - 600089

Human Factors In Patient Safety: A Nurse's Perspective

Lt Col Amita Naze (Retd)
Nursing Superintendent
Sree Narayana Institute of Medical Sciences
Ernakulam

Human factors are universally applicable across all workplaces involving human activity, and they are recognized as the universal aspect of human fallibility across various contexts. Common human variables that contribute to compromised patient safety incidents, as observed by nurses, include failures in communication, insufficient training, a lack of collaboration, diversions, and personal life pressures that impact psychological well-being.

Human Factors that lead to adverse events:
Human factors have a significant role in causing adverse events in health care. It may include:
- communication errors leading to medication errors,
- fatigue-related lapses in attention during critical tasks,
- teamwork issues causing delays in emergency responses,
- distractions causing errors in procedures,
- inadequate training contributing to procedural errors, and
- personal life stressors impacting a nurse's mental focus and emotional well-being, potentially affecting patient care.

Measures to Mitigate – a Nurse Manager's role:
To mitigate the possibility of human error in healthcare, it is necessary to:
- improve communication protocols,
- provide comprehensive and ongoing training,
- foster a culture of teamwork and open communication,
- minimize distractions in the work environment,
- implement fatigue management measures, and
- offer support to enhance psychological well - being

Nurses can enhance patient safety by promoting effective communication, collaborating with the healthcare team, conducting comprehensive and ongoing training sessions, adhering to evidence-based practices and protocols, conducting regular risk assessments, and advocating for patient education. Additionally, addressing nurses' psychological well-being through periodic counselling services, continuous positive reinforcement, establishing staff development programmes, maintaining a flexible work arrangement to address personal life challenges and work-life balance initiatives can contribute to a safer healthcare environment. Fear of workplace repercussions stemming from professional errors further compounds the challenges in maintaining a safe healthcare environment.

Nurses can encourage open communication channels without fear of retribution. Providing regular forums to discuss safety issues and solutions. Offering assertiveness training for effective communication. Recognizing and rewarding individuals who speak up about safety. Providing education on safety protocols and the importance of speaking up. Creating a supportive environment that values input from all team members. Implementing reporting systems that ensure anonymity and follow-up on reported concerns. Leading by example, demonstrating the positive impact of speaking up for patient care. Hold regular meetings or forums dedicated to discussing safety concerns and solutions openly.

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Increasing Nurse Retention Through Meaningful Recognition

Vinod Kumaar
ANEI Patient Safety Fellow, 2021

Nurses are the backbone of the healthcare system, providing vital patient care and support. However, the healthcare industry is grappling with a persistent challenge – Retention of Nurses. High turnover rates among nurses have serious implications for the quality of patient care and pose significant financial burdens for healthcare organizations. One often underutilized strategy to combat this issue is providing meaningful recognition to nurses.

This article delves into the importance of meaningful recognition in boosting nurse retention and offers a comprehensive understanding of its implementation. The Importance of Nurse Retention Nurse retention is a critical issue that profoundly affects healthcare institutions. High nurse turnover has far-reaching consequences, including a detrimental impact on patient care. When experienced nurses resign & leave, they are often replaced by less experienced staff, which can impact the quality of care provided.

Moreover, the cost associated with recruiting and training new nurses is substantial, making it financially prudent for healthcare organizations to focus on retaining their existing nursing staff. Understanding Meaningful recognition goes beyond mere token gestures or hollow words of appreciation. It entails acknowledging nurses' hard work, dedication, and contributions in a sincere and personalized manner.

True recognition should be tailored to the individual nurse's preferences and should align with the organization's values and goals. It is about making nurses feel valued, respected, and appreciated for their daily efforts. Ways to Implement Meaningful Recognition are as follows:

1. Verbal Appreciation: One of the simplest yet most effective ways to recognize nurses is through verbal appreciation. Supervisors and colleagues can express their gratitude sincerely, both privately and publicly, for the dedication and hard work of nurses. These words of encouragement can go a long way in boosting morale and motivation.

2. Awards and Honours: Healthcare organizations can create awards and honours for outstanding nurses, such as "Nurse of the Year" or "Excellence in Patient Care." These awards can serve as tangible symbols of appreciation and can inspire others to strive for excellence.

3. Professional Growth Opportunities: Meaningful recognition can also manifest through the provision of opportunities for professional development. This includes offering nurses access to continuing education programs, mentorship opportunities, and career advancement paths. Such investments not only show that the organization values the nurse's long-term career growth but also help in enhancing their skills and knowledge.

4. Financial Incentives: Tangible rewards such as bonuses, pay raises, or performance-based incentives can be another way to recognize and appreciate nurses. When nurses see that their hard work is directly tied to their financial well-being, they are more likely to stay committed to their organization.

5. Work-Life Balance Support: Meaningful recognition can extend to the implementation of policies that support a healthy work-life balance. Flexible scheduling, generous time-off benefits, and other measures that enable nurses to balance their professional and personal lives can significantly improve nurse satisfaction and retention.

Benefits of Meaningful Recognition
The implementation of meaningful recognition programs can yield a host of benefits in nurse retention and the overall performance of healthcare organizations:

1. Improved Job Satisfaction: When nurses feel genuinely appreciated and valued, their overall job satisfaction increases. This elevated job satisfaction can translate into a reduced desire to seek employment elsewhere.

2. Enhanced Motivation: Recognition serves as a powerful motivator. When nurses receive sincere appreciation for their hard work and dedication, they are more likely to remain motivated to maintain high standards of care and consistently go the extra mile in their roles.

3. Increased Loyalty: Nurses who receive meaningful recognition are more likely to develop a strong sense of loyalty to their organization. This loyalty can be a valuable asset, contributing to long-term commitment and reduced turnover.

4. Better Patient Care: Satisfied, motivated nurses are more likely to provide better patient care. When nurses feel valued and appreciated, they are more likely to be engaged and deliver high-quality care, leading to improved health outcomes for patients.

5. Cost Savings: Nurse turnover is costly. By reducing nurse turnover through meaningful recognition, healthcare organizations can save substantial amounts of money spent on recruitment, onboarding, and training. The cost savings alone make it a wise investment in the organization's financial well-being.

Conclusion
Meaningful recognition is a potent and often underestimated strategy for increasing nurse retention. It is imperative for healthcare organizations to prioritize creating a culture of appreciation that is tailored to the unique needs and preferences. By doing so, they can ensure that nurses are not only more likely to stay with the organization but also motivated to consistently deliver high-quality patient care. In the long run, investing in meaningful recognition is not only an investment in the well-being of healthcare institutions but also in the health and well-being of the communities they serve. By recognizing and appreciating the dedication and hard work of nurses, organizations can create a positive cycle of nurse retention, job satisfaction, and ultimately, improved Quality patient care and ensure patient safety.

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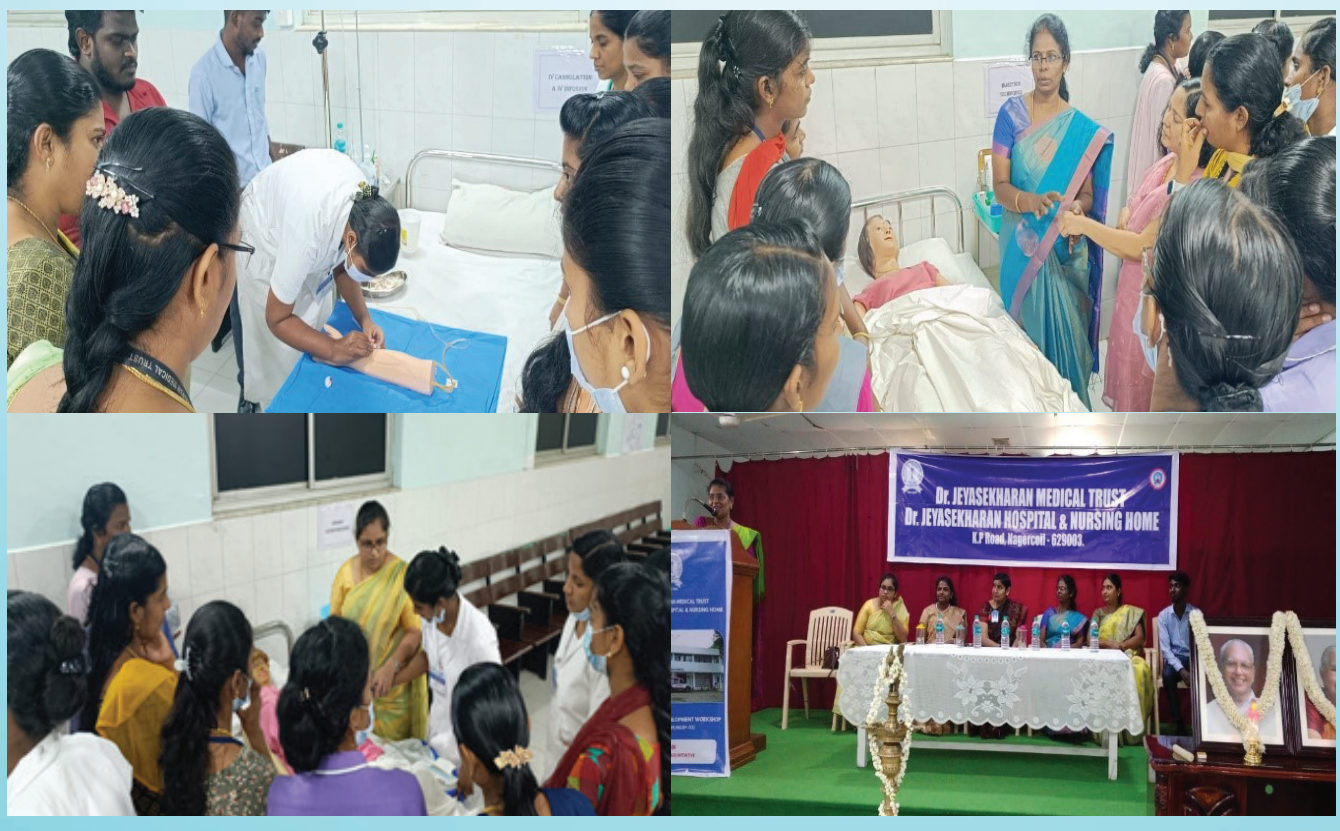
Report on Nursing Skill Development workshop

An AHPI & ANEI collaboration activity at TamilNadu

Meenakshi Hospital, Thanjavur

We had the workshop conducted at Meenakshi Hospital, Thanjavur on Sep 21, 2023, we had Ms. Baby Lakshmi, Ms. Arokia Sophi, and Ms. Subha, ANEI Members from TN chapter as Trainers for the workshop. We had on site, Dr Rosaline, VP, ANEI TN Chapter represented ANEI and speak about AHPI and ANEI. **We had the second workshop conducted at Dr. Jeyasekharan Medical Trust, Nagercoil** on Dec 9, 2023, we had Ms. Maheshwari, Ms. Venkatasaperumal, and Ms. Saranya, ANEI Members from TN chapter as Trainers for the workshop. We had on site, Ms Baby Lakshmi, ANEI Member, TN Chapter represented ANEI and speak about AHPI and ANEI. The skills covered during the workshop were Injection Techniques, IV Cannulation, Urinary Catheterization, ECG, Nasogastric Tube Insertion and Wound Care Management. 45 freshmen nurses in each hospital were trained hands-on using simulation technique with mannequins.

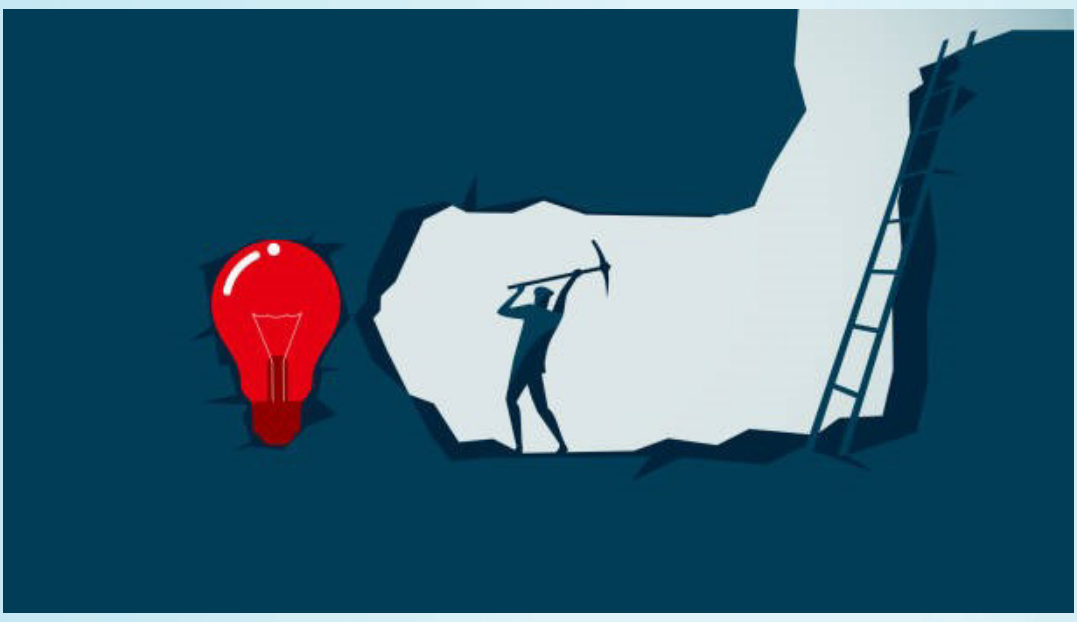
The session took place at Meenakshi Hospital in Thanjavur on September 21, 2023. The trainers for the programme were Ms. Baby Lakshmi, Ms. Arokia Sophi, and Ms. Subha, who are members of the ANEI TN branch. Dr. Rosaline, the Vice President of the ANEI TN Chapter, graced the occasion with her presence and delivered a speech on the various activities conducted by AHPI and ANEI. The second session took place at Dr. Jeyasekharan Medical Trust in Nagercoil on December 9, 2023. The trainers for the course were Ms. Maheshwari, Ms. Venkatasaperumal, and Ms. Saranya, who are members of the TN branch of ANEI. Ms. Baby Lakshmi, a member of the ANEI, TN Chapter, was present on site to represent ANEI and deliver a speech regarding AHPI (Association of Healthcare Providers of India) and ANEI. The programme focused on teaching Injection Techniques, IV Cannulation, Urinary Catheterization, ECG, Nasogastric Tube Insertion, and Wound Care Management. 45 freshmen nurses in each hospital were trained hands-on using simulation technique with mannequins.



Dr. Jeyasekharan Medical Trust, Nagercoil

Root cause analysis...only if we digger deeper shall we find what we seek

Ms. Pearl Cruz
Lead Research Nurse- Haematology NHS UK
Member, ANEI



As the name suggests, root cause can be found only if we dig deep enough to understand the problem and the associated process. As an amateur Qualitist I believed that not all problems may have a root cause. Say for example, the nurse after checking the vital signs missed to document on the patient chart. She did take the vitals but she missed and we cannot do anything but train her on importance of documenting and ways to increase the document efficiency without missing it. But as I accumulated wisdom and grew up to in this field, thanks to all my mentors in Healthcare Quality, I firmly started believing that "Errors belong to system and the system belongs to management". So whether you like it or not, error belongs to the people who run the organization and we as the leaders need to look at fixing the system and not the person. Hence to know what is it that we need to fix, we need to know why something went wrong & there lies your skill set of root cause analysis. Now when somebody tells me that the staff forgot to do something, I go back & look at why my staff forgot to do the job. Did we not give the adequate time or did we not give the adequate tools or did we not create an environment which enables my staff to remember what he or she is supposed to do? With every root cause analysis that I did, I learnt more & more about the possibility of errors. The complexity of healthcare is crazy & so are its problems. Crazy problems when solved well bring out great learnings & process driven solutions.

Let me give you classic examples of 2 similar errors which led to different solutions. Every Qualitist that is reading this article will agree with me that in their career as Qualitist must have, at least once. For instance, when received an incident report on Sponge count mismatch in the OR, the first thing that the OR nurse does in such instance is to stop the surgeon from closing the surgical wound -> look around in the waste bins, in the trolley, scan the patient with C-arm -> if the patient is clear of the sponge, good news your patient can be safely wheeled out but your nurse will not rest until she finds the missing sponge. Well if she doesn't find it, the incident report finds its way to the Quality desk. And then the team of Quality dons their microscopic lens to break the scenario & dig right down to where it started. So my dear readers let us travel this journey together, shall we?

Incident 1: Sponge count mismatch during an abdominal surgery. All possible steps done but sponge not found. Not retained in patient, not found in the OT, then where did it go? Well in this case, the lost sponge never existed in the first place!!! Amused? I was too. To ease the counting, every pack comes with a count of 5 sponges, so every time the nurse opens the pack & lays it down on the tray, she knows it is in the multiples of 5. She counts it again to ensure it but as the patient was bleeding profusely she hurries up. At the end of the surgery she had opened 8 packs adding up to 40 sponges in total. But there were only 39 soaked sponges in return. Cut to the chase, the empty wrappers of each pack were checked & one pack among them said "pack of 4". Was it the mistake of the scrub nurse who didn't count the sponges thoroughly? May be not. But how did this "pack of 4" land up in the trolley. So, do we blame the nurse who set the trolley? May be not. Do we say the error was by the nurse who was assigned to receive CSSD stocks & missed catching this pack which in the first place shouldn't have entered the OR premises? May be not. Then it's probably the mistake of the CSSD technician who allowed this pack to enter the hospital premises. So should we be fixing the process of receiving the sponge packs? There are thousands of such packs that enter the hospital & its humanely impossible to check every pack. Then maybe we should tell the nurse to check each pack when she receives it in the OR. "There are hundreds of packs she receives each day & I will have to allocate a manpower for it", I can hear the CNO saying. Well, then the nurse who prepares the trolley & the scrub nurse should ensure the count. She does it but when you have a complex environment, human errors of counting are bound to happen. So then how do we fix this? Accountabilities by each stakeholder is important but as an organisation who could afford newer technology, the management realized its time to make that investment. All the sponges were tagged with RFID & an RFID locator machine was procured. Now the counting job & also the pre-closure sponge count scanning is done by this machine. As a process we ensured that we add pre-closure scanning as a part of mandatory step of safe surgery checklist. Error fixed by management....coz errors belong to management

Incident 2: Sponge count mismatch during gynaecology surgery. 14 sponges went in but 15 came out. One additional sponge. Now how did that happen? 14 as per the scrub nurse, 14 as per the circulatory nurse's board. Pre-closure scanning done as per the new policy & now it revealed one additional sponge in the cavity. It helped us to locate the sponge but looks like our problem of sponge count mismatch still existed. Time for us to again wear our microscopic lenses & go through our process once again. All steps of the process followed...tick...all done. So what went wrong? Here's the catch. This patient was operated at another hospital & got admitted with us with complaints of lower abdominal pain. Although a pre surgical x ray was taken, the patient was obese the film did not completely capture the upper left quadrant. So apparently there was a retained sponge from a previous surgery from another hospital. Our root cause led us to an error from another hospital. So, do we close this case by saying its off our limits? No, nope, nada. Patient safety is way too important & we all need to build an ecosystem to catch unsafe practices. It was decided that in such cases where in the patient is obese appropriate X rays covering the entire field or 2 X rays, distributing the parts, to be taken & ratified by a senior radiology consultant. This got added in the policy with insights & approvals from senior consultants.

In my 20 years of healthcare career, there is no other tool I have faith in as much as the RCA. Dig deeper & you shall find the right cause & a right solution befitting the cause. So my young peers in the field of Quality, go forth....seek & you shall find.

Unveiling the Impact of Adverse Events: Understanding Third Victim Syndrome

Thankam Gomez
Founder Former President (ANEI)
Founder CEO, Cygnia Healthcare

In the complex world of healthcare, the repercussions of adverse events extend beyond patients and their families, reaching even those indirectly involved. While the concept of second victims, referring to healthcare workers, has gained recognition, a deeper exploration reveals the existence of a third group—the third victims. This article sheds light on the largely overlooked realm of third victim syndrome, focusing on the plight of patient safety professionals immersed in incident investigation and improvement activities.

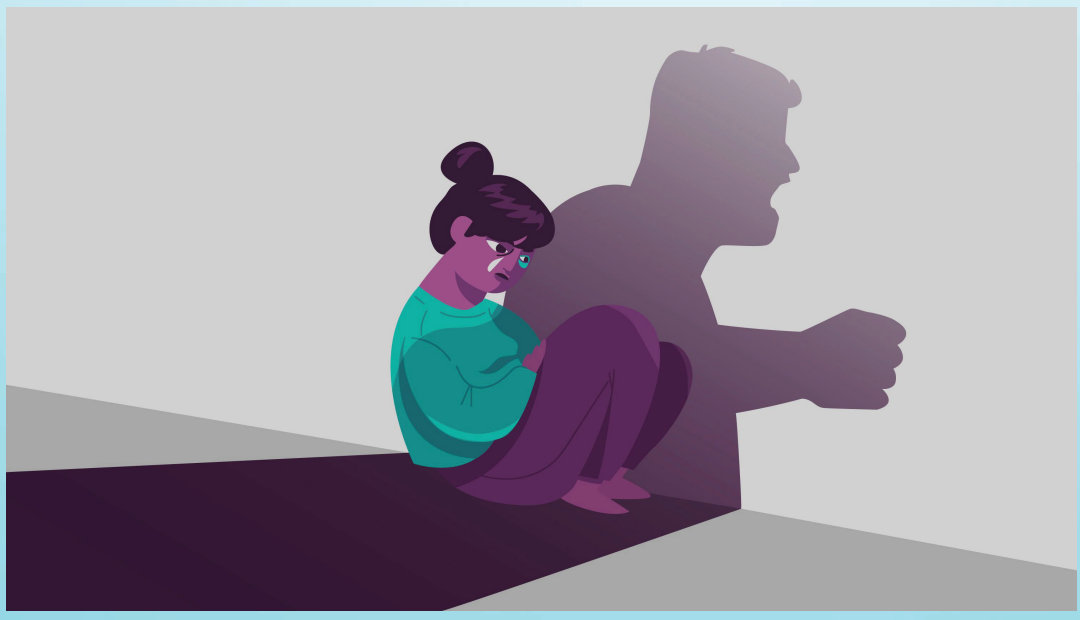
The sources of harm for third victims are diverse and profound. Critical incident stress, emotional labor, abusive supervision, and competing loyalties/duties form a formidable array of stressors. These challenges may manifest as symptoms of acute stress disorder or post-traumatic stress disorder, erode confidence, induce economic harm, and, in severe cases, drive patient safety professionals away from their noble profession.

To address this growing concern, a multifaceted approach is imperative. First and foremost, extending second victim support services to encompass patient safety professionals becomes crucial. By recognizing the unique stressors they face, healthcare institutions can provide tailored assistance, ensuring the mental and emotional well-being of these dedicated individuals.

Furthermore, redesigning the patient safety role is essential. Introducing measures to mitigate the emotional toll of incident investigations and improvement activities can significantly contribute to preventing third-victim syndrome. Board-level and senior management leadership are pivotal in fostering a culture of psychological safety, where professionals feel secure in expressing concerns and seeking support without fear of repercussions.

In tracking metrics related to third victims, healthcare organizations can gain insights into the prevalence and nature of harm experienced by these professionals. This data can inform targeted interventions and facilitate the development of a comprehensive strategy to prevent and mitigate third-victim syndrome.

As we bring attention to this critical issue, the call to action for the research community is clear. It is time to delve deeper into characterizing the sources and types of harm experienced by third victims, conducting rigorous studies, and testing interventions to fortify the healthcare system against this silent but impactful adversary. By doing so, we can safeguard the well-being of those who tirelessly work to improve patient safety and ensure the resilience of our healthcare workforce.



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