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Caring cards: How to prevent patient harm in hospitals

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As nurse leaders, we strive to motivate and lead staff nurses to improve quality of care and prevent patient harm. Reliable methods and auditing processes only take us so far. Nurses complain that these become rote tasks and can either be forgotten or lead to disenchantment with the staff as they focus on remembering tasks. Rather than thinking critically or engaging with their patients, nurses are no longer enamored with patient care, contributing to burnout and turnover. Caring cards is a unique innovation, building on reliable lean processes by adding in the way we emotionally care for people. The foundational constructs of a nursing theory are paired with aspects of universal fall precautions. Conversations between leaders and staff provide a way for the nurse to describe their critical thinking about fall prevention individualized to that particular patient. Additionally, leaders collect barriers to care from the staff and create a board that demonstrates follow through to staff raising concerns. The audience will be able to takeaway samples of caring cards and how to implement them in their setting. This will include the process for using the cards, tips for the critical thinking discussion with the staff, how to elicit and record and resolve barriers noted by staff, and how to create a simple visibility board using the caring card system. The impact of the caring card pilot has been substantial. The data collected showed patient falls were greatly reduced on the pilot unit from rate as high as 19.72 improved to a rate of 5.43 per 1000 patient days. This unique method shows promise in preventing harm and saving lives. Several key learnings for the audience will occur. Focused conversations with staff can help improve critical thinking and allow leaders to fix barriers that interfere with staff's ability to keep patients safe. Caring cards enhance lean methodology by incorporating nursing theory to help staff engage with patients and leaders engage with staff. The use of visibility and improvement boards can help prevent harm. Caring cards can be used to prevent patient falls, hospital acquired pressure injuries, and improve pain management and for additional nursing care applications. The caring card methodology is applicable in other healthcare settings and has the potential to be used with any nursing process where nurse leaders want to see patient care outcomes improve. The pilot focused on patient falls and was also expanded to pain management and hospital acquired pressure injuries. In the future, we intend to expand it to prevent post-sheath removal vascular bleeding, catheter-associated urinary tract infections, and central line associated blood stream infections.

Learning Outcome:

1. Learners will be able to apply the concept of caring cards to coach staff in preventing harm in the healthcare setting.
2. Learners will be able to demonstrate the use of caring cards to identify barriers staff experience that contribute to patient harm.

Key Concepts:

Caring cards, an innovative alternative to process audits, allow nurse leaders to discuss and coach staff in preventing patient harm. This presentation will highlight the use of caring cards to show a reduction in patient falls as staff describe to leaders their critical thinking in preventing falls as well as outlining barriers they experienced in upholding universal fall precautions. Replacing traditional audits and checklists, the caring card method includes a visual system, an improvement board, and a staff reward system.

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