

Improvement Taiwan Patient-safety Reporting system

Incidents through Walkrounds Awareness and Willingness

Pin-Jung, Lu , Yu-Yun, Huang , Ke-Yung, Chuang

Quality management Department, Taipei Medical University Hospital, Taipei, Taiwan

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INTRODUCTION

Introduced in December 2003 by the Ministry of Health and Welfare (MOHW), the Taiwan Patient-safety Reporting System (TPR) serves as a nationwide incident reporting system. It encourages healthcare professionals to anonymously, voluntarily, and confidentially report patient safety incidents, with a focus on collective learning and without assigning blame. The primary objective is to promote learning across diverse healthcare institutions by sharing information about patient safety events, enabling healthcare professionals to self-identify errors, and establishing mechanisms for error prevention to mitigate the recurrence of similar incidents.

The practice of "Walkrounds" has been established in the United States and the United Kingdom for several years. Our institution adopted this approach in 2021 to enhance communication between hospital leadership and staff across various units. This initiative aims to convey the hospital's philosophy, listen to the perspectives of frontline staff, and cultivate a sense of value and importance among the staff through two-way communication.

AIM

The aim of this event is to emphasize the significance of reporting patient safety incidents through Walkrounds and to raise awareness about the patient safety reporting system. The objective is to boost medical personnel' willingness to report patient safety.

METHOD

- **【Selection Criteria】** Two wards of a hospital with the highest and lowest number of patient safety incident reports from January to August 2023, and eleven medical service units, totaling fifteen units.
- **【Event Period】** October 20, 2023 - November 23, 2023
- **【Participants】** Ward/Unit Directors, Head Nurses, Ward/Unit Staff, Medical Personnel of the Ward (such as dietitians, laboratory technicians, etc.)

醫品惡談-異常事件通報知多少

了解醫品惡談-異常事件通報如何處理，本文將藉由匿名方式，請教於醫師。
調查時間：102/11/20~11/22/週四
調查對象：本文專攻泌尿泌尿科醫師(共 8 位)

255176@tw.bnu.edu.tw [tw 帳號](#) 

本 4 月 4 日 12 日

* 表示必須閱讀

0 請問你最近有通報過病人安全事件？

☐ 是

☐ 否

4 請問對醫學領域病人安全事件通報意願如何(可複選)？

☐ 主要對醫療事件通報(如跌倒/誤服)

☐ 對非醫療事件(如設備故障)

☐ 對管理事件(如感染控制)

☐ 對學術事件(如學術不端)

☐ 通報方便程度、輸入方式等

☐ 通報系統設計與介面

☐ 不良反應通報制度

1-1.QPI執行討論 (11101-11208)

【東研院針對各項議題進行說明與執行建議】

議題	討論重點與建議說明	重要討論事項說明
東研院行政系統、人事工作系統發展與完善	持續優化中	研擬各項系統優化與改善計畫
東研院行政系統、人事工作系統發展與完善	持續優化中	研擬各項系統優化與改善計畫
東研院行政系統、人事工作系統發展與完善	持續優化中	研擬各項系統優化與改善計畫

100~111年度非體科生件數統計分析

年次	100	101	102	103	104	105	106	107	108	109	110	111
非體科生件數(總計)	3,712	3,940	4,122	4,070	4,897	5,313	5,062	5,102	5,517	6,628	6,887	7,231
非體科生件數(%)	5.8	5.4	6.2	6.0	8.2	10.6	9.7	9.7	8.5	12.7	12.5	13.8

1-2.通報執行討論 (111.01-112.08)		TMU
困難點	需要協助說明	
保安通報流程複雜，事件發生頻率低，致使同仁對通報流程及方法不熟。	定期舉辦教育訓練指導同仁如何通報	
提升校園安全與緊急事件通報建議		
1. 向同仁宣導防範異常事件通報重要性，以及加強教育訓練。		



STEP1 : Anonymous questionnaire survey on colleagues' awareness of patient safety incident reporting

STEP2 : Ask the unit to point out the difficulties in implementing patient safety incident reporting

STEP3 : 15 minutes to review recent unusual events or audit results.

STEP4 : 45 minutes of interviews to understand the unit' s quality control and convey the hospital' s policies and concepts.
And express condolences to colleagues with souvenirs.

RESULTS

Through the pre-test questionnaire survey conducted as part of the Walkrounds (n=136), it was found that nearly half of the colleagues are unclear about hospital policies.

For example 1. the provision of a 100 NT dollar reporting reward if a reported patient safety incident is substantiated, and 2. Reporting patient safety incidents is done anonymously.

The top three factors influencing colleagues' willingness to report patient safety incidents include the hospital's ability to handle reported incidents effectively, followed by supervisors' supportive attitudes towards reporting such incidents, with the severity of the incident ranking third.

Throughout the Walkrounds, conducted in 15 units, it was observed that some colleagues were unclear about the reporting process for patient safety incidents, which indirectly impacted their willingness to report.

Following the conclusion of the event, we collected feedback through a questionnaire to evaluate medical personnel' awareness of hospital policies. It was observed that awareness among colleagues regarding the provision of a 100 NT dollar reporting reward if a reported incident is substantiated increased from 60.3% to 86.9%. Additionally, awareness among unit colleagues regarding the "anonymous" nature of reporting patient safety incidents increased from 47.8% to 78.7%.

CONCLUSIONS

This event not only aims to improve the "Taiwan Patient-safety Reporting System (TPR)" but also sheds light on approximately 46 issues related to healthcare quality and patient safety, with 21 issues among them that pertain to the entire institution.

Engage in direct conversations with medical personnel through hospital leadership.

It allows medical personnel to perceive the genuine concern of hospital leadership, empowering them to openly express difficulties and problems.

This not only recognizes that medical personnel have a channel to voice the current situation but also provides hospital leadership with insights into the challenges of clinical operations.

Through the influence of leadership, improvements can be implemented to address issues and enhance healthcare quality.

CONTACT INFORMATION

Pin-Jung, LU
Administrative Officer
Taipei Medical University Hospital
EMAIL : 225178@h.tmu.edu.tw



臺北醫學大學附設醫院
TAIPEI MEDICAL UNIVERSITY HOSPITAL