Medication Error Events: Development of a Just Culture Policy

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The Policy Issue

• Children’s Hospital Colorado (CHCO)
  • Organizational focus on quality and safety
  • Medication errors

• Event review process at CHCO
  • Creates feelings of shame/blame
  • Nurses’ experience with medication errors

• Need for non-punitive policy
  • Just culture model for nurse managers

(Pepe & Cataldo, 2011; Serembus et al., 2001; Treiber & Jones, 2010)
The Practice Issue

- Medication administration
  - Fundamental nursing task
  - Nurses at risk for error
  - Technological advances
    - Increase patient safety
    - Reduce medication errors
  - Nurses experience distress following medication error

(Rassin, Kanti, & Silner, 2005; Treiber & Jones, 2010)
Practice Issue Background

- Multiple factors lead to medication error
  - System or organizational
  - Nurses’ personal/professional incompetence
- Blame
  - Self and peers
    - Personal/professional effects
- Nurses as second victims
  - Physical, emotional, psychological effects
  - Alienation and abandonment

(Jones & Treiber, 2010; LaDuke, 2000; Rassin et al., 2005; Schelbred & Nord, 2007; Serembus et al., 2001; Smetzer, 2012; Treiber & Jones, 2010; White et al., 2008; Wolf et al., 2000)
Practice Issue Stakeholders

- Health care organizations
  - Nursing management
  - Hospital administration
- Professional organizations
  - Patient safety
  - Quality
  - Nursing

(Khatri et al., 2009; Philipsen, 2011)
Need for Policy

• Practice issue holds consequences
• Current organizational practice at CHCO
  • Risk management questioning
  • Physician reprimands
• Just Culture Policy for Medication Error Events
  • Interdisciplinary event review process
  • Enable nurses’ reconciliation of feelings

(Khatri et al., 2009; Schelbred & Nord, 2007; Smetzer, 2012; White et al., 2008)
Just Culture as Policy

• Just Culture
  • Highlights open discussion
    • Organizational transparency
  • Discovery
    • Systems or organizational causes
  • Improve systems and processes
    • Increases safety
  • Removes individual spotlight
    • Non-punitive
Policy Goals

1. Compassionate care for nurses in distress
   • Nurse managers
     • Increase support
     • Allocate resources

2. Promote open communication
   • Human fallibility happens
   • Develop on-site support team
3. Develop algorithm for nurse managers
   • Lead through event and nurses’ reaction
   • Direct toward appropriate support mechanism
Policy Cost/Benefits Issues

- Financial costs limited
  - Training
  - Support team
- Enhance cost benefits
  - Human resources
  - Patient safety
  - Quality care delivery
Policy Alternatives

- No alternative to policy purpose
- Modifications to algorithm
  - Nurse manager discretion
- Support team development
  - Timeline
- Changes to meet organizational readiness
Policy Fit with Established Goals

- Aligns with established organizational goals
  - Patient and workplace safety
  - Quality care delivery
- Feasible
  - Requires modifying current organizational culture
  - Continues safety system enhancements
Recommendations

- Establish Just Culture Policy for Medication Error Events
- Enhance manager support for nursing staff
  - Care and compassion
- Develop algorithm and support team
  - Promptly address nurses’ distress
  - Facilitate transcendence through distress
Policy Presentation

- Organizational leadership
  - Executive Leadership Council
  - Nursing Governance Board
  - Clinical Operations Council
  - Human Resources
- Nursing management
  - Nursing staff
References


Smetzer, J. (2012). Don’t abandon the “second victims” of medical errors. *Nursing, 42*(2), 54-58. DOI: 10.1079/01.NURSE.0000410310.38734.e0.
