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MEDICATION ERRORS AND THE INTRODUCTION OF "JUST CULTURE"

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BACKGROUND / EVIDENCE

- LVHN is transitioning from a universal Tiered Medication Error Severity Process to a "Just Culture" environment.
- Many factors contribute to medication errors: interruptions, heavy workload, inadequate staffing, non-supportive physical environment, poor colleague relations, lack of time, and nurse's experience level (Kim & Bates, 2012)
- Only 10% of medication errors are reported by nurses due to fear of retaliation (Leufer & Cleary-Holdforth, 2013)
- When nurses make medication errors, they may experience shock, dread, horror, panic, shame, guilt and denial (Schelbred & Nord, 2007)
- "Just Culture" is a balance of the need to learn from mistakes and the need to take disciplinary action. It focuses on the root cause of errors and recognizes that errors may be systemic rather than a personal failure (Tocco & Blum, 2013).
- Turnover rates are inversely associated with supportive environments, especially for new nurses (Shepard, 2011)

PROCESS / IMPLEMENTATION

- Inclusion Criteria: October 2016 Nurse Resident Cohort
- Pre-survey distributed to assess nursing knowledge of "Just Culture" and the Medication Error Severity Tier Process in January prior to intervention
- Intervention: Educational PowerPoint distributed to nurse residents on "Just Culture" and the Medication Error Severity Tier Process in February
- Post-survey distributed along with education to reassess knowledge on "Just Culture" and the Medication Error Severity Tier Process and preference between the two when reporting medication errors

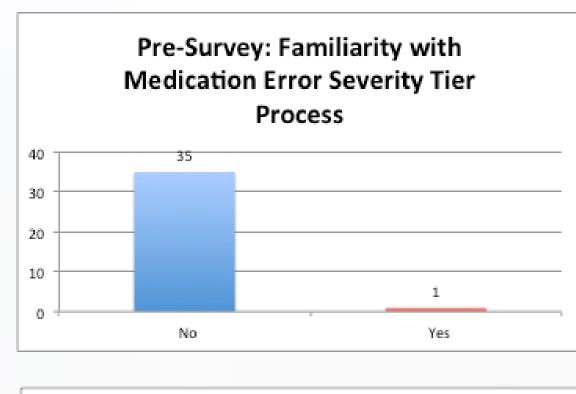
PURPOSE

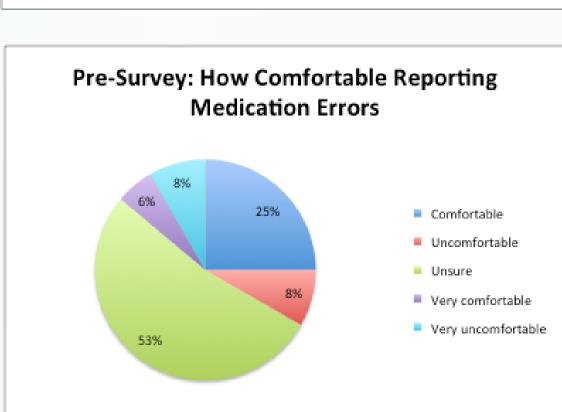
The purpose of this project is to determine whether nurses are more comfortable reporting medication errors using the "Just Culture" model or the Medication Error Severity Tier Process.

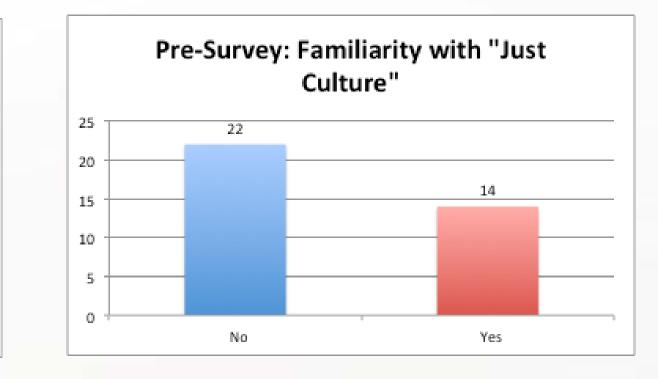
- P: New nurses
- I: Education of Medication Error Severity Tier Processs and Just Culture
- C: No knowledge
- O: Awareness and better understanding of "Just Culture" and Medication Error Severity Tier Process.

EXPECTED OUTCOMES

- Familiarize staff with "Just Culture" concepts.
- Change perception so that errors are viewed as part of a larger systemic problem rather than an individual failure
- Allow for more open and honest discussion among nurses when medication errors occur to increase knowledge and safety
- Enable healthcare workers to view error reporting as something that leads to improved policies and procedures (Tocco & Blum, 2013)

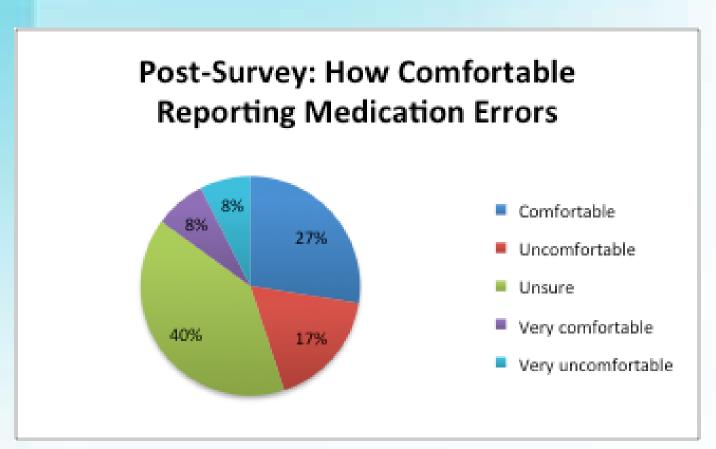


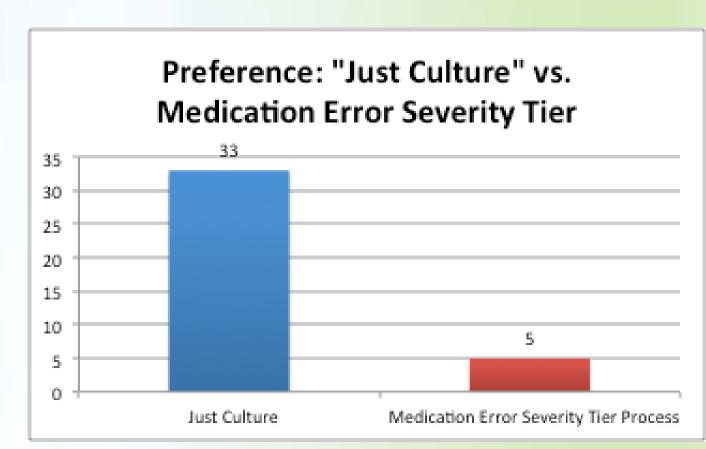




CONCLUSIONS / RESULTS

- Increased familiarity with "Just Culture" and the Medication Error Severity Tier Process
- More nurses reporting that they are uncomfortable with reporting errors under the Medication Error Severity Tier Process after education
- Preference of "Just Culture" over the Medication Error Severity Tier Process when reporting medication errors





NEXT STEPS

- Serves as supporting evidence for the introduction of "Just Culture" into the network
- Implementation of "Just Culture" into the network during the next fiscal year
- Potentially increase retention rates of nurses, especially new nurses, using the "Just Culture" model

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