New Hanover Regional Medical Center

Recognition & Reporting of Medication Errors

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Significance

- Emergency departments (EDs) across the country are overcrowded, have sicker patients with multiple issues, and are noted to have increased pressure to treat and disposition patients very quickly (Affleck et al., 2013).
- Challenges resulting from the ED's demanding environment, lack of experienced staff, and the increased risk of potential harm to patients from medication errors and ADEs present a national problem of unsafe practice (Weant et al., 2014).
- Some nurses are uncomfortable with medication error reporting because they do not understand the fundamental reason for reporting (Hohenhaus, 2008).

Purpose

- To implement an evidence-based practice (EBP) change focused on improving medication error recognition and reporting by ED nurses through education, utilization of leader rounding and coaching to facilitate a culture of safety, transparency, and learning avoiding punitive measures in the event an error occurs.

Methodology

- A pre/post evaluation of the number of medication errors reported.
- Three Press-Ganey employee engagement questions from 2015 were used to assess staff attitudes toward medication safety pre/post implementation.
- Computer-based and face to face education: What constitutes an error; what to do if an error is made; & culture of safety.
- Leadership support and coaching post education via rounding and appreciative inquiry.

Findings

Change in Error Reporting

	Pre	Post	Change
Percentage of reports/doses administered	0.14%	0.19%	0.05%

Note. Pre-data collected April-May 2017. Post-data collected July-Aug 2017.

Staff Attitudes Toward Safety

	Pre (n=185)	Post (n=85)	Change
Employees make every effort to deliver safe care	4.61	4.76	0.15
I can report errors without fear of punishment	4.29	3.63	(0.66)
I feel comfortable raising concerns if I see and error	4.38	4.64	0.26

Note. Staff attitudes measure via Press-Ganey employee engagement survey pre-2015, post-2017.

Implications

- Decreasing a culture of fear will improve the culture of safety.
- Staff understanding of medication error reporting is necessary to improve patient safety.
- Education and support for staff is important to ensure understanding of related processes.

Next Steps

- Continue staff journey toward a culture of safety through continued leadership support, coaching, and transparency.
- Refine and provide education to staff to gain deeper understanding of a safety culture.
- Engage the Unit Based Practice Councils of the three network EDs to evaluate current safety measures and recommend improvements using Lean methodology.
- Consider the development of an ED Safety Committee to review errors using the NC Board of Nursing complaint evaluation tool or the Just Culture Algorithm.
- Consider using the Global Trigger Tool (GTT) method from the IHI to retrospectively review errors as opposed to strictly relying on variance reporting (Harkanen, Turunen, Vehyilainen-Julkien, (2016).

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References: Affleck et al., 2013: Harkanen, et al., 2016, Hohenhaus, 2008: Weant, et al.,2014