Correcting error reporting systems

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Correcting Error Reporting Systems HA 255-01 April 5, 2011 2 A sophisticated continuous quality improvement process should involve the clinical employees as well as the senior medical staff. “ Leading an organization refers to an individual’s ability to galvanize resources and motivate employees to work collectively to further organizational goals, which goes beyond simply controlling day-to-day operations. ” (O'Connor, 2009) Continuous quality improvement cannot function properly without effective leadership and managers who have a dual role in managing staff as well being a part of the leadership of the organization as a whole.

By definition, continuous quality improvement involves employee empowerment and interdisciplinary teams. By only utilizing the senior nurse manager in monthly CQI meetings, clinical staff, which are a very integral part of the overall process, were undermined in the improvement and organizational forward motion of the facility. While the managers were satisfied with the formal changes and the decrease in medical error reporting, the clinical staff was not satisfied as they were not included or informed nor did they have any input regarding the feasibility of medical error reporting.

CQI has become a pivotal tool at use in health care organizations. Engaging and empowering all staff in a health care facility lends to growth both personally and organizationally within a health care system. Job performance and satisfaction in the work place environment are impacted positively as a result of employee’s being able to participate in the structured monthly meetings of the organization. The segregation of clinical staff and management does not lend to the prosperity of a health care facility.

When implementing a CQI process to reduce medical errors, I would involve the clinical staff as well as they do have practical experience and the knowledge of what is feasible in a real life situation. 3 When including a CQI process to reduce medical errors, the entire clinical staff would be involved in conceiving and implementing of the disciplinary action assigned to reported errors. Involvement at every level of the facility would create an atmosphere of teamwork and inclusion. In the case study scenario, the senior management and leadership had set themselves apart from the clinical staff.

Since the clinical staff was not consulted regarding discipline and the discipline was punitive, the senior leadership succeeded in creating a barrier and ostracizing themselves rather than creating an atmosphere of continuity. As more health care organizations are implementing a CQI process along with a non- punitive reporting system, management systems must also be adjusted to avoid such scenarios in their respective work place. A great management team relies on the employees to be effective. They cannot lead if they do not have anyone that follows.

Employees must have some empowerment and some level of inclusion. When a new human resource consultant was hired to investigate the problem in the case scenario, the work ethic the clinical staff was forced to adopt as a result of the punitive reporting system was discovered and corrected. What appealed to the senior management early on regarding the systematic and formal process that medical error reporting would be conducted was not actually effective at all since staff were not always filling out incident reports to avoid the punitive reporting system. A punitive,

person-centered approach therefore, severely hampers effective improvements in safety. ” (Webster, 2001) The senior management had a false sense of success which I feel could have been avoided if the clinical staff would have been consulted regarding the quality of care and safety in the nursing home. Often it is relatively simply to address these issues by empowering the very individuals who rules apply to. The clinical staff knows what works and what will not be effective and through inclusion in the 4 rocess they develop a sense of pride and responsibility that is not present in a segregated managerial system. In an article entitled Medication Error Reporting: CQI Programs Offer Avenue to Vital Follow-Up, a minimum of 27 states require hospitals as well as other health care facilities to report serious medical errors. It further goes on to say that "…error reporting forms only one part of a comprehensive CQI program …it allows managers to identify problems, assess best solutions, and measure uccesses. ” (Medication Error Reporting: CQI Programs Offer Avenue to Vital Follow-Up, 2011) Based on this article, CQI and punitive reporting systems is probably not a common coexistence since CQI programs identify the problem as associated with the process and not necessarily as a result of individuals. It would typically seek a non-punitive approach to errors and concentrate its efforts on changing the process to ensure a repeated incident did not occur again.

When incorporating an incident reporting and performance appraisal system into a health care organization, special attention needs to be given to ensure the systems works in tandem to improve the overall function of the operation. Performance appraisal systems have historically not been

effective tools in improving the quality of the performance of the individual which the appraisal evaluates. Managers need accountability in performing these appraisals possibly by having the appraisal reflect back to some degree to the manager responsible for the employee.

The typical employee will only take the appraisal process as serious as his or her manager does. Management, at least in this regard, sets the tone for the employee's attitude regarding the performance appraisal process. Performance based appraisals should be an ongoing process with 5 shown marked improvement or progress. Lack of personal performance growth would result in consequences for the employee including a probationary period or dismissal. Personal conflicts between manager and employee should not be reflected in the appraisal process.

Manager accountability would be reflected by the performance of the employee; hence, an ineffective manager could as easily be discovered through the process as an ineffective employee could be. The process would actually be a system of checks and balances. Ideally, this would promote team players and identify any weak links. The goal of performance appraisals is utilizing the employee's performance and their behavior or attitude. With correct implementation, the attitude and behavior will not be the issue or focus of the manager. For any performance improvement to take place, both parties must agree that improvement is necessary, that a plan for improving performance has been jointly formulated, and that periodic progress improvement sessions will take place, as needed. Thus, improvements in employee performance and attitudes can truly be enhanced. " (Peggy Anderson, 1998) Through ongoing training and

development, clinical errors should be mostly nonexistent. However, an incident reporting system needs to be in place. The incident reporting system should not seek to be punitive in nature but identify and correct the cause of the incident.

More harm can result from employees being scared to report the error because of the punitive nature they are dealt with then by the actual error. The error needs to be on record so no further harm comes to the patient while the cause of the error needs to be addressed. The punitive reporting system is not effective when employees are circumventing the reporting system. The goal is not to punish for errors but to address and correct the source of the problem? Is the individual 6 incompetent to perform the duties required of the position? Was the error a simple over sight? Was the error a result of the employee being too tired or overworked?

Were medications properly labeled and prescription order clearly indicated? It is much more critical to address and correct the issue to ensure that the same errors are not repeated. A host of questions must be considered when an error occurs. Continued training, personal performance appraisals, work environment and many other factors are critical in reducing medical errors. I would therefore change the incident reporting system to take into account these various circumstances and have a reprimand system included with a probationary period when negligence on the part of the employee was found to be the reason for the error.

The reporting system should always allow for change and corrects as methods are discovered to effective or not so effective. However, the

primary goal is always the safety and care of the patient. 7 Medication Error
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