

Change management plan to reduce medication errors



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Assignment 2 Change Management Plan: reducing medication errors by building a dual medication error reporting system with a 'no fault, no blame' culture

Introduction

Medication errors in hospitals are found to be the most common health-threatening mistakes made in Australia (Victoria Quality Council, n. d.). Adverse events caused by medication errors can affect patient care, leading to increased mortality rates, lengthy hospital stays and higher health costs (Agency for Healthcare Research and Quality, 2012). Although it is absolutely impossible to eliminate all medication errors as human errors can occur, reporting errors is fundamental to error prevention. “ Ramifications of errors can provide critical information to inform the modification or creation of policies and procedures for averting similar errors from harming future patients” (Hughes, 2008, p. 334). Thus, it highlights the importance of change management to provide a reporting system for effective error reporting. In this paper, the author is going to explore current incident-reporting systems and discuss the potential benefit of a dual medication-error reporting system, with a 'no fault, no blame' culture through a literature review, followed by a clear rationale for the necessity of a change management plan to be in place. Lippitt's *Seven Steps of Change* theory will be demonstrated in detail with clear strategies suggested for assessing the plan outcomes. Finally, the main issues will be summarised with an insightful conclusion.

Discussion

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Medicines are the most common treatment used in the Australian healthcare system, which can make great contributions in relieving symptoms and preventing or treating illness (Australian Commission on Safety and Quality in Health Care, 2010). However, because medicines are so prevalently used, incidences of errors associated with the use of medicine are also high (Aronson, 2009). Over 770, 000 people are harmed or die each year in hospital due to adverse drug events, which can cost up to 5. 6 million dollars per year per hospital. Medication errors account for one out of 854 inpatient deaths and it is notable that the number of medication error-related death is higher than motor vehicle accidents, breast cancers and AIDS mortality (Hughes, 2008).

Reporting enables a platform for errors to be documented and analysed to evaluate causes and create strategies to improve safety. A qualitative study (Victoria Quality Council, n. d) was conducted to survey the current medication error reporting systems in both metropolitan and rural hospitals in Victoria. Most hospitals prefer the report to be named as it allows follow-up of the incidents, whereas only a small proportion of hospitals use anonymous reporting to alleviate the barrier of reporting yet the correlation with actual errors has been low. In addition, a majority of hospitals acknowledged that near misses are supposed to be recorded but are rarely documented ().

It is clear that errors and near misses are key to improve safety, so they should be reported regardless of whether an error resulted in patient harm. A near-miss error that has the potential to cause a serious event does not

negate the fact that it was and still is an error. Reporting near misses is invaluable to reveal hidden danger.

Hughes (2008) pointed out that the majority believes a mandatory, non-confidential incident report system could lead to and encourage lawsuits thus a reduced frequency of error reports resulted. A voluntary and confidential reporting system is preferred, which encourages the reporting of near misses and generates accurate error reports. However there is concern that with voluntary reporting, the true frequency of both errors and near misses could be much higher than what is actually reported (White, 2011). Thus, it can be concluded that a dual system combining both, mandatory and voluntary mechanisms might improve reporting.

Although nurses should not be blamed or punished for medication errors, they are accountable for own actions. Therefore, reporting errors should not attribute blame to individuals but to 'hold providers accountable for performance' and 'provide information that leads to improved safety' (Hughes, 2008). Individuals and organisations attention needs to be drawn toward improving the error reporting system, which means to 'focus on a bad system more than bad people' (Wachter, 2009). Reporting of errors should be encouraged by creating a 'no fault no blame' culture.

Rationale:

Medication errors can occur as a result of human mistakes or system errors. Every medication error can be associated with more than one error-producing condition, such as staff being busy, tired and engaging in multiple tasks (Cheragi, Manoocheri, Mohammadnejad & Ehsani, 2013). Nurses are <https://assignbuster.com/change-management-plan-to-reduce-medication-errors/>

most involved at the medication administration phase and are the last people involved in the drug delivery system. It becomes the nurses' responsibility to double check prior to the administration of medication and to capture any potential drug error that might be made by the prescribing doctor or pharmacy. Whether the nurse is the source or an observer of a medication error, organisations rely on nurses as front-line staff to report medication errors (Hartnell, MacKinnon, Sketris, & Fleming, 2012).

When things go wrong, the most common initial reaction is to conceal the mistake. Not surprisingly, most errors are only reported when a patient is seriously harmed or when the error could not be easily covered up (Hughes, 2008). Reporting potentially harmful errors before harm is done, is as important as reporting the ones that harm patients. The barriers to error reporting can be attributed to the workplace culture of blame and punishment. Blaming someone does not change those contributing factors and a similar error is likely to reoccur. Adverse drug events caused by medication errors are costly, preventable and potentially avoidable (Australian Commission on Safety and Quality in Health Care, 2009). Thus, it is essential that interventions to be implemented must ensure a competent and safe medication delivery system. To do so, change is needed; to adopt a dual medication error reporting system with a 'no fault, no blame' culture in Holmesglen Hospital.

Change Management Plan:

The Nursing role has evolved to match the ongoing growth of the Australian health-care delivery system. There is a trend for nurses to take responsibility

for facilitating positive change in areas related to health (Steanncyk, Hancock & Meadows, 2013). Nurses play the role of change agents which is vital for the effective provision of quality healthcare. There are many ways to implement changes in the work environment. Lippitt's *Seven Steps of Change* theory is one of the approaches believed to be more useful as it incorporates a detailed, step by step plan of how to generate change (Mitchell, 2013). There are seven phases in the theory:

Phase 1: The Change management plan begins at this phase to provide a detailed diagnosis of what the problem is. No matter what reporting procedures are in place, they may capture only a fraction of actual errors (Montesi&Lechi, 2009). Reporting medication errors remain dependent on the nurses' decision making, and the nurses may be hesitant or avoidant to report errors due to fear of consequences. A combination of mandatory and voluntaryreport system is suggested with a ' no fault no blame' approach to reduce cultural and psychological barrier (Hughes, 2008).

Both statistical review and one to one informal interviews can help to identify areas that need attention and improvement. An open door policy and disclosure preferences for nurses who want to express their concerns, either to a nurse unit manager, a nurse in charge, a supervisor, a senior or a nurse representative or a colleague are all suitable. This approach can be effective in exploring and uncovering deep-seated emotions, motivations and attitudes when dealing with sensitive matters (??). Statistical review, such as RiskMan reviews, is a useful tool to capture and classify medication errors (Riskman, 2011). Holmesglen hospital are conducting bi-monthly statistic reviews to gather information on the contributing factors of medication
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errors, by aiming to target system issues that could contribute to the error made by individuals, and make a change at organisational levels. For example, if medication errors are constantly caused by staff who are distracted or exhausted, staffing levels and break times will be reviewed.

Phase 2: At this stage, motivation and capacity to change are assessed. It involves small group activities such as staff meetings or medication in-services and all nursing staff are invited. Feedback can be given either directly (face to face) or in-directly (survey) and nursing staff knowledge, desire and skills necessary for the change as well as their attitude for change are assessed. Staff motivation can be reflected through rates of meeting attendance, number of submitted surveys, or number of staff who actively participated in the meeting discussion. Nurses who have good insight and are actively involved in the meeting are the 'driving forces' which will facilitate the process of change management; nurses who are hesitant or adverse to change are the resisting forces, in which force-field analysis can be used to counter this resistance (Mitchell, 2013). Force-field analysis is a framework for problem solving. For example, with the health budget crisis we face today in Australia, many hospitals and units may have financial restraints and are incapable of maintaining the flow of the change process. In the meetings, financial issues can be brought up at organisational levels that making change is necessary for both better patient outcomes and reducing unnecessary healthcare costs.

Phase 3: With the motivation and capacity levels addressed, determining who the change agent is and whether the change agent has the ability to make a change. Change agents can be any enthusiastic person who has <https://assignbuster.com/change-management-plan-to-reduce-medication-errors/>

great interest, has a genuine desire and commitment to see positive change. Daisy is a full time associated nurse unit manager (ANUM) employed by Holmesglen hospital for some years. As she has a background of being a pharmacist, part of her role includes providing drug advice to nurses. During her weekly medication review, Daisy noticed that medication errors have been frequently occurring but there is little correlation with the actual reports submitted. Daisy decided to run in-service sessions and all nurses are invited to attend. Daisy discussed her change management plan with the nurse unit manager who also expressed interest and agreed to provide human resources and reasonable financial support. Another four ANUM also expressed interest and commitment. It has been arranged that two ANUM to attend the in-service at each time.

Phase 4: The in-service is designed to be running for 6 months from September 15th 2014 to March 15th 2015 on monthly basis. Daisy will be holding the in-service and other ANUM will provide assistance in implementing the change plan. The in-service will consist of two parts and run for two hours. The first hour will be a review of the performance of the last month along with relevant statistics. The second hour will be self-reflection and discussion. All participants will be paid for attendance and encouraged to complete an anonymous survey monthly.

Phase 5: Daisy is the leader of the change agents responsible for conducting in-services, collating information regarding medication safety, and summarising data with the assistance of ANUM. Meanwhile, Daisy and all the ANUM are the senior staff responsible for providing supervision and support

to junior staff and other nurses. A monthly summary report of performance is submitted to the leader for review and monthly meetings are held among senior groups to review the effectiveness of the change management plan and adjust and modify the current plan if needed.

Phase 6: A communication folder will be used to update nurses about past meetings. A drop box is available in the staff room for anonymous suggestion and complaints, which can only be accessed by Daisy and the other 4 ANUM. All suggestions and complaints will be responded with two weeks of submission in written form and available in the staff room for all staff to read in the feedback section in the communication folder.

Phase 7: The change management plan will be evaluated at the end of the 6 month period the 30th of March 2015, to determine whether the change management plan has been effective. The evaluating process can be done through audit or feedback. The change agent will withdraw from the leader position after the final meeting but still work on the ward to provide ongoing consultation. The four ANUM will take over the role to ensure a good standard is maintained. The drop box will remain available for any further issues identified in the work place.

Clear strategies for assessing the plan outcomes

As previously mentioned, a final evaluation will be conducted after the final in-service utilising two main approaches to assess the plan outcome - auditing and feedback. Auditing includes internal review and an external audit; feedback consists of nursing staff feedback and patients report.

An internal review will be conducted four times through the following year. The ANUM are assigned to conduct the review. The Review includes comparing the medication charts with the incident reports to assess any correlation. For example, an omitted dose is considered a reportable medication error and an incident report should exist correlatively.

An external medication audit will be conducted by an external professional to provide a true and fair reflection of the situation (??). It can occur annually, not only to assess the plan outcome, but to also monitor practices and identify areas for improvement. Frequency of auditing will depend on the rate of staff changing. However, every newly employed nurse will be given a printout to familiarise themselves with the change that has been made with an open-door policy encouraging queries. If significant non-compliance is identified in the auditing, it is suggested that the first phase of change management plan should be repeated to assess the necessity for modification of the current plan (Australian Commission on Safety and Quality in Health Care, 2014a).

The drop box will still be available for anyone who experiences or witnesses medication errors, or have a better suggestion to improve practice. Submission is anonymous and confidential. Only the ANUM have access. Public feedback will be given to complaints and suggestions in a timely manner and in the form of a printout for all staff to read. Patients can be a source of reporting medication errors as some of them know what their regular medications are. Also, new side effects experienced by patients can reflect the inappropriate use of medication.

Conclusion-highlight main issues 250

Need to be completed — Barriers to report errors must be breached to accomplish a safer medication administration system. Reporting medication errors and near misses through an established reporting system can provide opportunities to reduce similar errors in the further nursing practice and alleviate costs involved in such adverse events. Several factors are necessary in the change management plan: a leader that is motivated and committed to make a change; a reporting system that makes nursing staff feel safe;