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Association Report

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APhA–APPM

Changing the Conversation

In his testimony before a U.S. Congressional subcommittee, Dr. Lucian Leape made a bold claim that the single greatest impediment to error prevention is that "we punish people for making mistakes."

Anderson

Hultgren

Shortly thereafter, the Institute of Medicine (IOM) published its seminal work on patient safety, *To Err is Human*, which found that 44,000 to 98,000 people die in hospitals each year because of medical errors that could have been prevented.[1] At the time, this would make medical error the fifth leading cause of death in the United States, behind cardiovascular disease and cancer.[2]

If health care systems are unintentionally harming patients, and one of the greatest obstacles in preventing this harm is the fact that individuals are punished for their mistakes, then what can we do to change the status quo? Changing the culture of an entire organization is a daunting task, one that may seem so monumental that there is little room for individual effort. What can a single professional do when faced with such a dilemma? We can change the conversation.

When a medication error is identified, health care leaders should ask "Why?" instead of "Who?". We should ask about the system instead of focusing on the individual. People will certainly play a role at some point, but by starting the dialogue with facts about why something took place, it changes the tenor away from an inquisition to one of inquiry.

The idea of a process-focused instead of person-focused approach is included within the concept of just culture. This framework is frequently referenced by health care organizations. But what does "just culture" mean? According to the Agency for Healthcare Research and Quality, a just culture "focuses on identifying and addressing systems issues that lead individuals to engage in unsafe behaviors, while maintaining individual accountability by establishing zero tolerance for reckless behavior."[3]

In essence, a just culture–focused organization strives to make changes to the health care system to prevent the errors from occurring again, while treating individuals fairly when they make mistakes and maintaining an unsympathetic stance toward intentional risk taking.

David Marx, an engineer and attorney by training, published a classic patient safety piece that helped to define the different kinds of behaviors involved in medical errors.[4] From his work, three behaviors are commonly referenced: human error, at-risk behavior, and reckless behavior.[5] As each of these behaviors have a different underlying cause, they all require a different approach toward the individual who was involved in the error.

Human error describes an unintentional behavior that causes or could cause an undesirable outcome.[4] Putting orange juice on top of breakfast cereal instead of milk is an example of a human error. One might not intend to put orange juice on top of their cereal; however, human error could lead to the undesired outcome. Human error can be further categorized into skill-based errors (slips and lapses) or mistakes (rule-based or knowledge-based)[6]; however, for the purposes of discussing just culture, it is most important to understand that this type of behavior is an unintentional act that may lead to harm.

At-risk behavior encompasses actions in which an individual loses the perception of the risk or believes that the unsafe behavior is justified.[5] For example, one pharmacist may receive recognition for checking a large number of prescriptions in a short amount of time, whereas another pharmacist might be criticized when they take longer because they perform standardized checks and thoroughly educate their patients on their medications. This concept of gradually accepting or drifting into more at-risk behavior over time is called *normalization of deviance*.[7] It is possible to experience this concept when traveling on the highway and witnessing others driving 5-10 miles/h faster than the posted speed limit. The drivers know the speed limit; however, it has become an acceptable risk over time to disregard it and drive slightly faster.

Reckless behavior, on the other hand, is behavior in which the individual consciously perceives the substantial riskiness of their behavior and chooses to continue regardless of the risk,[4,5] in contrast to at-risk behavior, such as driving 40-50 miles/h faster than the posted speed limit. This mindful

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disregard for unsafe behavior would be considered reckless.

Why is it important to understand the differences between these types of behavior? Because understanding the underlying causes behind these behaviors will help to craft the conversation and determine what corrective actions are necessary to address the error. For example, a case in which an individual selects hydralazine instead of hydroxyzine because of human error might be addressed by changing how the medication is stored. However, a case in which an individual knowingly dilutes a medication to save money calls for remedial or punitive action.[8]

Health care organizations and professionals should take steps toward improving their own cultures of safety by creating environments in which individuals are treated fairly when they make mistakes and held accountable for reckless behavior. Our institutions should move away from blindly punishing individuals for their mistakes and focus their efforts on preventing the error from happening again. They should pause and take a moment to consider the system and the environment where the error occurred before assigning blame to a pharmacist, a technician, or a health care provider. Ultimately, our profession needs to change its focus and the approach to medication errors—and we can start by changing the conversation.

Just culture resources

- The Just Culture Community (Outcome Engenuity): https://www.justculture.org/
- Agency for Healthcare Research and Quality (AHRQ) Safety Culture Primer: https://psnet.ahrq.gov/primers/primer/5/safety-culture
- Agency for Healthcare Research and Quality (AHRQ) Surveys on Patient Safety Culture: http://www.ahrq.gov/professionals/quality-patient-safety/patientsafetyculture/index.html
- ISMP Just Culture and Its Critical Link to Patient Safety:
  - Part I: http://www.ismp.org/newsletters/acutecare/showarticle.aspx?id=22
  - Part II: http://www.ismp.org/newsletters/acutecare/showarticle.aspx?id=26

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How Every Pharmacist Can Help Decrease Medication Errors and Sleep Better at Night

Warholak

Has this ever happened to you?

You work a busy shift at the pharmacy. After work, you come home, relax, and eventually go to sleep. Then, in the middle of the night, you awake suddenly because you are worried that you made a medication error. You sit in bed and try to retrace your steps. If that does not give you peace of mind, then you call the pharmacy (if it is a 24-h pharmacy) to have someone on duty check the records and put your mind at rest. If it is not a 24-hour pharmacy, you get up, get dressed, and drive to the pharmacy and check the records yourself so that you can go back to sleep.

This scenario has happened more times than I prefer to recollect, but it does not have to be this way if we are proactive and do all we can to improve the medication use systems in which we work. How can we decrease medication errors? Many of us were not taught quality improvement or medication error reduction techniques in school and, of course, there are time pressures at work. Well, luckily, there is help. Simply take the following steps.

How can every pharmacist decrease medication errors?

Get trained in quality improvement and medication error reduction

The Pharmacy Quality Alliance (PQA) has created free continuing education (CE) that is available online. Visit http://pqaalliance.org/academic/epiq/welcome.asp to start using Educating Pharmacists in Quality (EPIQ). EPIQ was designed to train practicing pharmacists, health professionals, and pharmacy students to improve the quality of care in pharmacy practice. It features 26 complimentary online sessions that can be accessed for CE credit for pharmacists, or downloaded for live CE or educational use. EPIQ materials are also available for pharmacy faculty and student pharmacists as a turnkey, 26-session course that can be used in its entirety as a full semester course or separated into individual sessions and integrated into an existing class.

Enlist student pharmacists to help you (and to learn)

In my experience, student pharmacists like to practice new skills in real-world settings. Involve students who serve as interns, clerkship students, technicians, or residents in helping your pharmacy to decrease medication errors and improve quality. EPIQ has online training videos that can be accessed by students, and it includes preceptor guides to help you have posteducational topic discussions with the students. Enlist students with all the following steps. It can provide not only a learning opportunity for the students, but also additional manpower (or woman power!) to get the project done.

Record all errors and near misses in a standardized manner

I completely agree with Drs. Anderson and Hultgren in their article titled *Changing the Conversation* that, "When a medication error is identified, health care leaders should ask 'Why?' instead of 'Who?'" It has been shown time and again that punishing a person who has