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Instructions

Presentation Poster – Tips and Instructions

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SLIDES

The PowerPoint template includes facility slides to choose from. In the View drop down menu, choose "Slide Sorter." In the Sorter, simply delete any slides not needed.

(To select multiple slides at once, hold down the shift key and hit delete.)

IMAGES

- Images used should be high-resolution jpeg files.
  Vendor is not responsible for poor image quality of low-resolution files.

CHARTS AND GRAPHS

- Limit color palette for clarity

EMAIL COMPLETED FILE TO

ColorDigital@TriangleRepro.com

SUBJECT LINE

- [Facility Name] Presentation Poster

INFORMATION TO INCLUDE WITH ORDER

- Your name
- Department name
- Department number for billing
- Poster Size
- Delivery instructions and/or note that you will pick-up

ADDITIONAL INSTRUCTIONS

- Add any additional instructions for the vendor (such as Velcro) as needed.

STANDARD OUTPUT

- Presentation Posters are printed on Mimaki 20oz Smooth Vinyl (durable) and rolled for delivery.

COST

- 5' x 3' Presentation Poster $75.00
- 6' x 4' Presentation Poster $120.00

VENDOR CONTACT INFORMATION

- Triangle Reprographics
  850 S. Hughey Ave.
  Orlando, FL 32801
  Customer Service: 407.843.1492

QUESTIONS

- Email: ohbrandsource@trianglerepro.com

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An Exploration of Nurses' Attitudes and Beliefs on Medication Error Reporting Practices: A Qualitative Study

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Background

- Between 210,000 and up to 400,000 preventable deaths occur every year due to medical errors and hospital harm
- Medication-related errors occur most frequently and those that reach the patient and result in harm are costly
- Incident reporting systems (IRS) were designed to capture these errors
- Following the publishing of *To Err is Human: Building a Safer Health System*, an increase in the implementation of IRSs across the nation was seen
- However, underreporting of medication errors leads to lack of understanding about error events limiting the ability to build strategies to prevent future errors
- Literature demonstrates that communication about errors and non-punitive responses from nurse leaders plays a significant role on nurses' willingness to report medication errors

Purpose

- The aim of the study was to explore nurses' perceptions and attitudes of medication error reporting practices

Methods

- Descriptive exploratory qualitative design
- Secondary analysis of mixed methods data from prior study
- Twenty-one (21) clinical nurses in nine (9) focused interview groups and two (2) one-on-one interviews were conducted
- Interviews occurred between March 2019 to November 2019
- Direct content analysis was used to determine codes and themes

Findings

- When evaluating how participants described errors and error reporting, internal factors or external factors that either hindered or supported the participant's reporting of medication errors were identified
- *Internal factors* described circumstances within nurses themselves that affect reporting such as **personal feelings** and **personal beliefs**
- **Personal feelings** were how they perceived or judged a situation and reacted
  - Examples include self-preservation, vulnerability, shame/guilt, feeling stupid/incompetent, and judged by others
- **Personal beliefs** were if they believed something as acceptable or true regardless if founded or unfounded by facts
  - Examples include error severity perception, reporting beliefs, loss of trust from co-workers, guilt in reporting others, and fear of retribution
- *External factors* were described as outside influences from **processes** (policies, rules, or guidelines) or **places**
- **Processes** include structure of reporting an error, leadership practices, and the communication with leaders
  - Examples include cumbersome reporting practices (repetitive/time-consuming), lack of leadership support for reporting, uneven accountability, and delay in follow-up
- **Places** were the nursing units themselves
  - Examples include lack of communication about errors on the unit, lack of error loop closure on unit
- One example of a unit-level reporting supportive practice included a nurse leader sharing the error event at the nurse practice council to educate and talk about how to prevent in the future

What Nurses Said…

- Internal Factors
  - "You're going to be talked about and think that you're a bad nurse, because you made a med error." (judged by others)
  - "How could I have been so stupid? And how could I have done that?" (feeling stupid/incompetent)
  - "[Medication errors are not reported because] maybe…..they don't think it's a big deal." (reporting beliefs)
- External Factors
  - "[The reporting system] it's very repetitive. They ask you the same question multiple times." (cumbersome reporting practices)
  - "The information is not fresh anymore. Sometimes I don't even remember the patient's name." (delay in follow-up)
  - [When reporting to leadership] "she looked at me and was like 'why are you telling me this'?" (lack of leadership support for reporting)

Conclusions and Implications

- Medication error reporting is a multidimensional phenomenon
- The perception of "safety culture" on nursing units impacts nurses' attitudes and willingness to report errors
- Error reporting is a professional responsibility of every nurse; therefore, actions need to be modeled by nurse leaders
- Unit culture that encourages and supports error reporting needs to be fostered by these leaders
- Potential study implications to improve error reporting may include strengthening unit level safety culture, enhancing nurse leader communication of errors and associated practices or processes changes, and nurse education on the error reporting process

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