Molde University College
Specialized University in Logistics

Responsibility Development

An initiative to establish a responsible system

Master in Health Science

Elfrid Måløy

RN, Assistant Professor

Research organisation:
Norwegian University of Science and Technology, Trondheim. NTNU. Norway.
Molde University College. Norway.

Research project

A study of medication errors or adverse events with medication among clinical nurses in hospitals in Norway

Purpose of the project

To highlight how the nurse related to the nursing culture in connection with medication errors and adverse events, and how these were handled

Background- Previous Research

- **Medication Errors - a relevant problem**
- **Among the most common and serious errors in health care**
- **Patient injuries; ”Tip of the Iceberg”**
- **Per year in Norway at least 10-15 deaths**
- **A significant fear among nurses**

Research Question

What can be found in the nursing culture in connection with medication errors and adverse events in hospitals?

Method: **Grounded Theory**

- Inspired by **Barney Glasers'** and **Anselm Strauss'** orginal version **from 1967**
- The goal of Grounded Theory: to reduse the distance between the empirial and theoretical level
  Induction is the basis
- Developing theory that is applicable in practice
- A qualitative study consisting of semi-structured individual interviews

The informants

- 10 nurses from
- 3 hospital wards from
- 2 hospitals in Norway

The interviews were conducted in 2006

FINDINGS

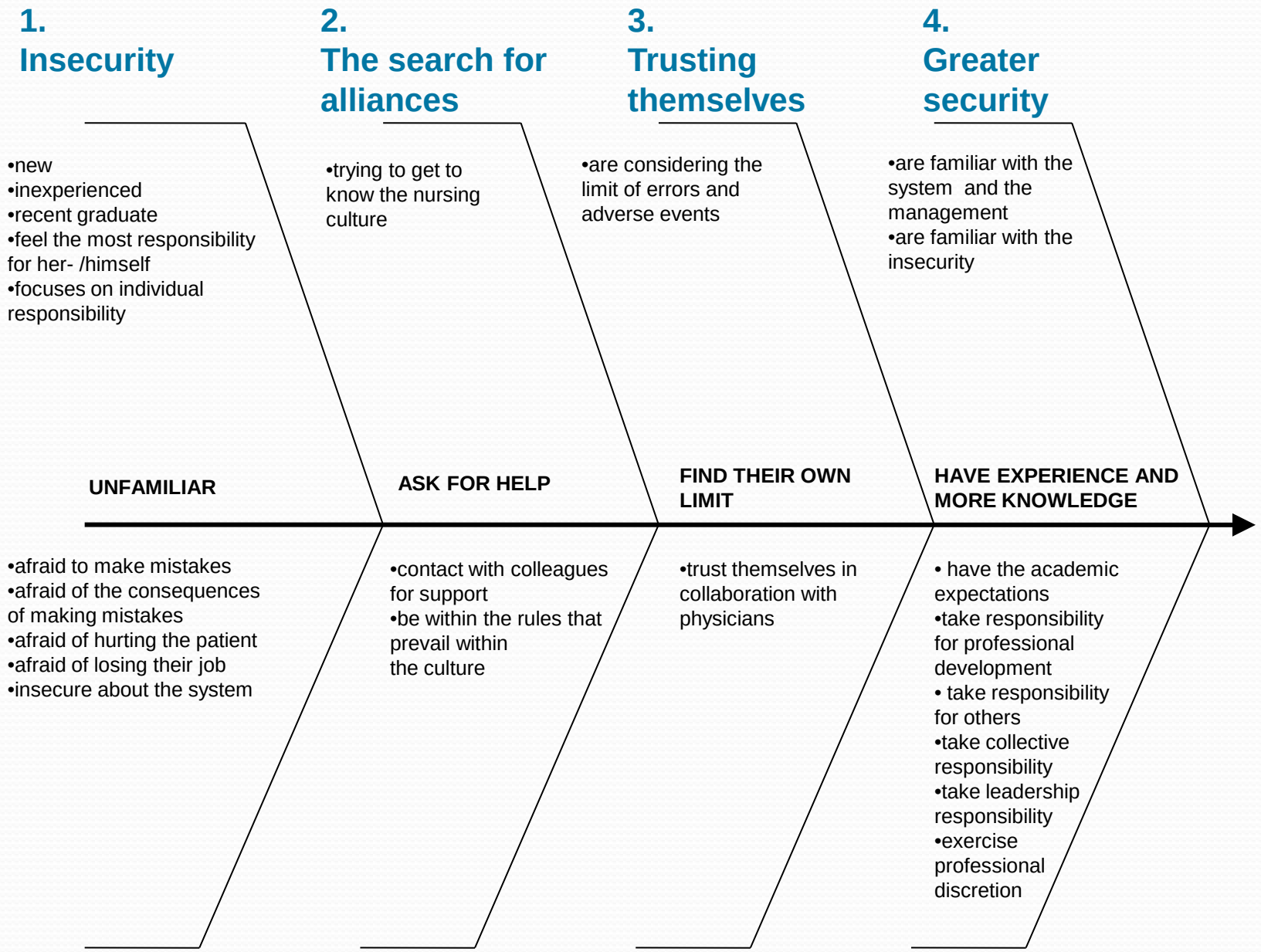
- **The main concern= ERRORS HAPPENS.** The nurses felt great responsibility when medication errors occurred. They wanted to contribute to improvements that address this issue.

- **The main dilemma = TIME PRESSURE.** A lot of work had to be done at the same time with constant interruptions. This had unfortunate consequences and involved sources of error.

- **The core category= RESPONSIBILITY DEVELOPMENT**

- **A basic social process =** The nurses undergo **Responsibility of Development Process (RDP)** in four (1- 4) phases.

Responsibility of Development Process (RDP)



Quote from the informants

Phase 1: Insecurity

Nurses says when it comes to errors:

... you are so afraid ... you get so scared ...
I'm just confident when I know it is right

It should not be done wrong and in relation to medicines that you give another person, a sick person and then made mistakes…. that is the worst of all…that can CAUSE patient harm.

Phase 2: The search for alliances

But I just ASK… you know. …Because it is not possible to be unsure. I'm just uncomfortable with it. One must just know.

Phase 3: To trust themselves

…but the question is what we do afterwards, when you discover the error. I believe we have slightly different practices

…if I do something wrong ... then I stop myself. I do.

there are different limits on what you put down… on the bedside table… We talk about it. At least I do

…It is not always we are equally agreed as to who will provide what (nurses and physicians) … either they do not know or they are too busy.

I have to say NO sometimes.

Phase 4: Greater security

We've got a responsibility ... if we see that something is not quite right. So we get geared up before it's done wrong

Yes, we have a solid training plan. But one can always ask the question in retrospect. Was it complete enough?

Improvement Potential

- **Patient safety**:

  - medication errors might entail serious consequences for human situations in retrospect

- **Greater transparency:**

  - In order to prevent errors and mistakes and that learning should take place;

  “Creating a safe culture”

- **Reporting culture:**

  - There is a long way left to go

- **Culture for Competence:**

  - A continuous process

Improvement Potential

- **Culture for good psychosocial environment:**
  - Recognition and respect
- **Physical conditions:**
  - Prevent crowded and messy rooms
- **Technological solutions:**
  - Data-driven medicine system
  - Electronic solutions
- **Framework Conditions:**
  - Resources and Organization

Conclusion

- RDP has shown that there is a complex interaction between the nurse as an individual, the nursing culture and the system.
- Nevertheless, this study is not intended to be a recipe for how medication errors can be eradicated.
- However RDP is a theory that reflects upon the nurse's competence within a system that has great potential for improvement in terms of transparency and resources, both in time and space.
- RDP is intended to be a theory that contributes to increased awareness of the nurse's point of view in a system that will ensure a great responsibility:

human life

Responsibility Development contributes to improvements for

patient safety

Elin Settemsdal 2008