ACCOUNTABILITY, NOT ACCUSATIONS: PROMOTING A JUST CULTURE IN MEDICATION PRACTICE

Elizabeth DeBell, PharmD

August 11th, 2026

NYSCHP Technician Miniseries

NYSCHP | New York State Council of Health-system Pharmacists

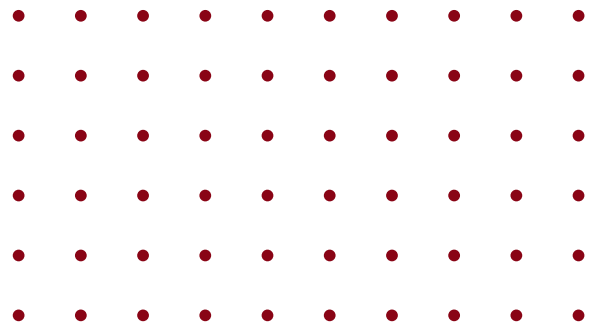
OBJECTIVES

PHARMACIST OBJECTIVES

1. Recognize individual and system accountability
2. Address and eliminate barriers to medication error reporting
3. Recognize the psychological impact of medication errors
4. Promote a supportive environment focused on learning and improvement rather than blame

TECHNICIAN OBJECTIVES

1. Differentiate between the types of accountabilities
2. List barriers to medication error reporting
3. Identify medication errors and their psychological impact
4. Demonstrate a culture focused on learning rather than blame



NYSCHP | New York State Council of Health-system Pharmacists

NO CONFLICTS OF INTEREST

TO DISCLOSE

Just Culture

If reporting an error could cost you your job, would you still report it?

NYSCHP | New York State Council of Health-system Pharmacists

Origins of Just Culture

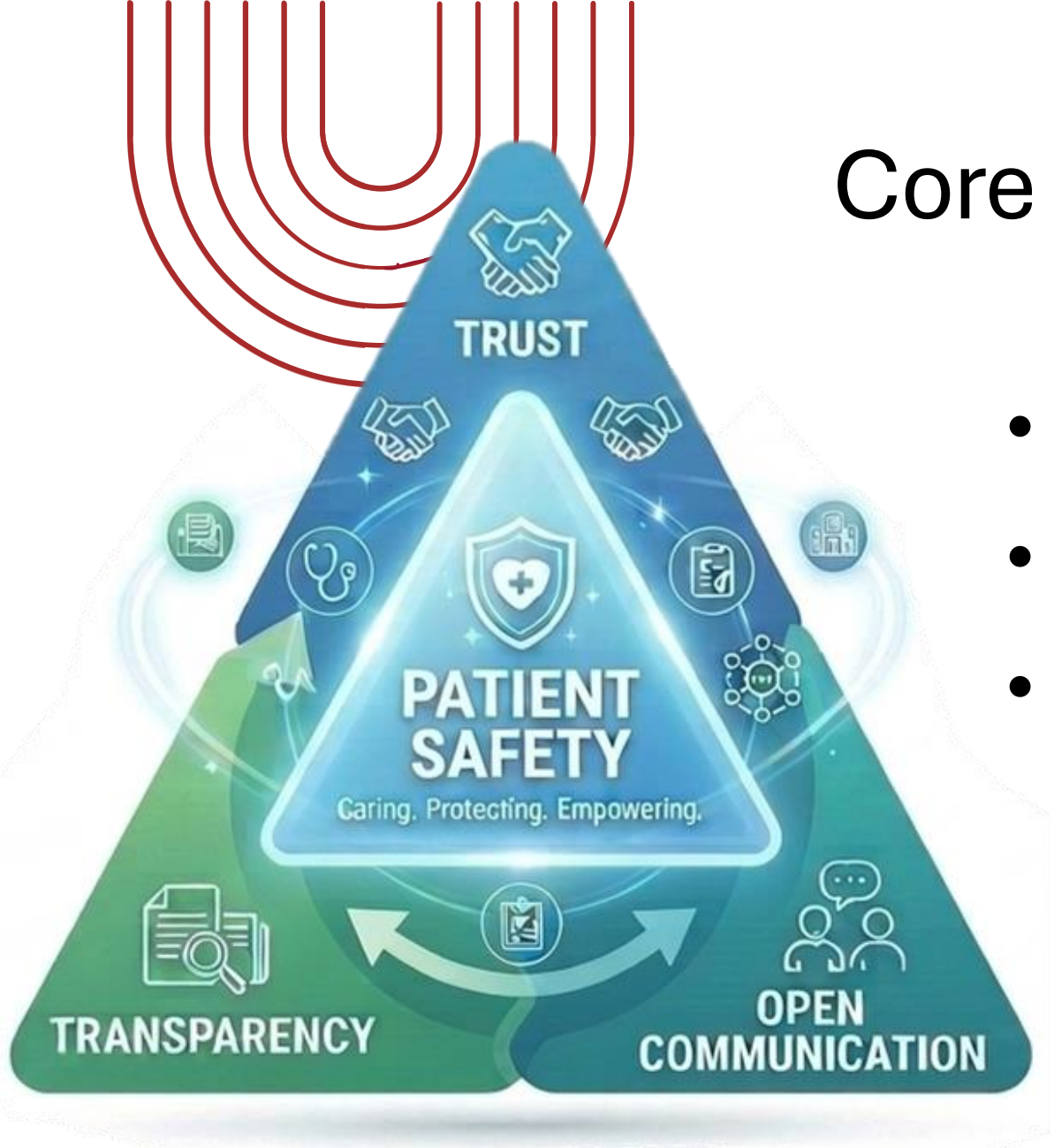
High-Risk or High-Hazard industries

- Mistakes could cost hundreds of lives
- Blaming individuals discouraged reporting
- Loss of information about system vulnerabilities

Need for change

- Learn from mistakes
- Minimize errors
- Safe environments

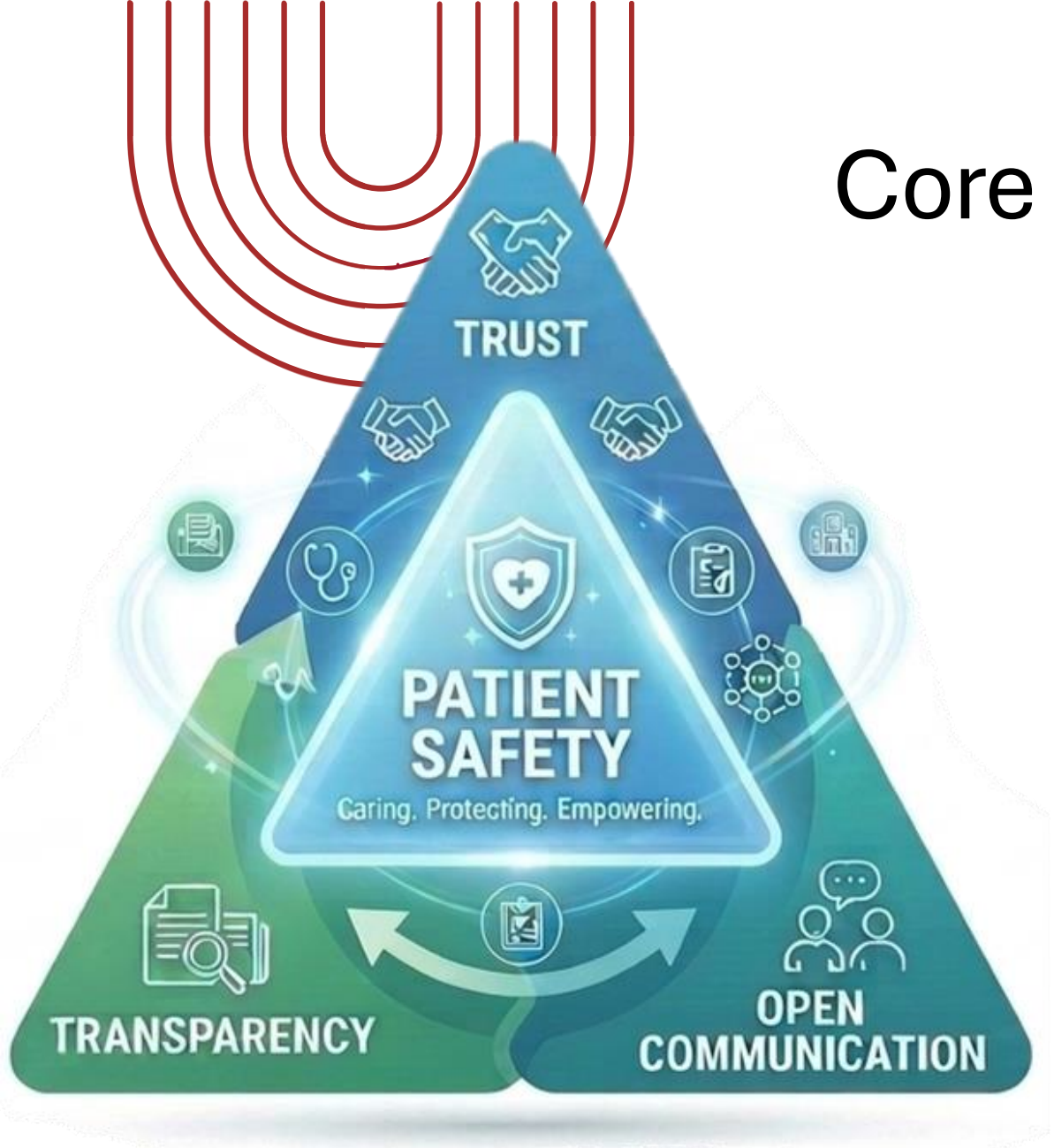
NYSCHP | New York State Council of Health-system Pharmacists



Core Principles of Just Culture

- **TRUST**
- **TRANSPARENCY**
- **OPEN COMMUNICATION**

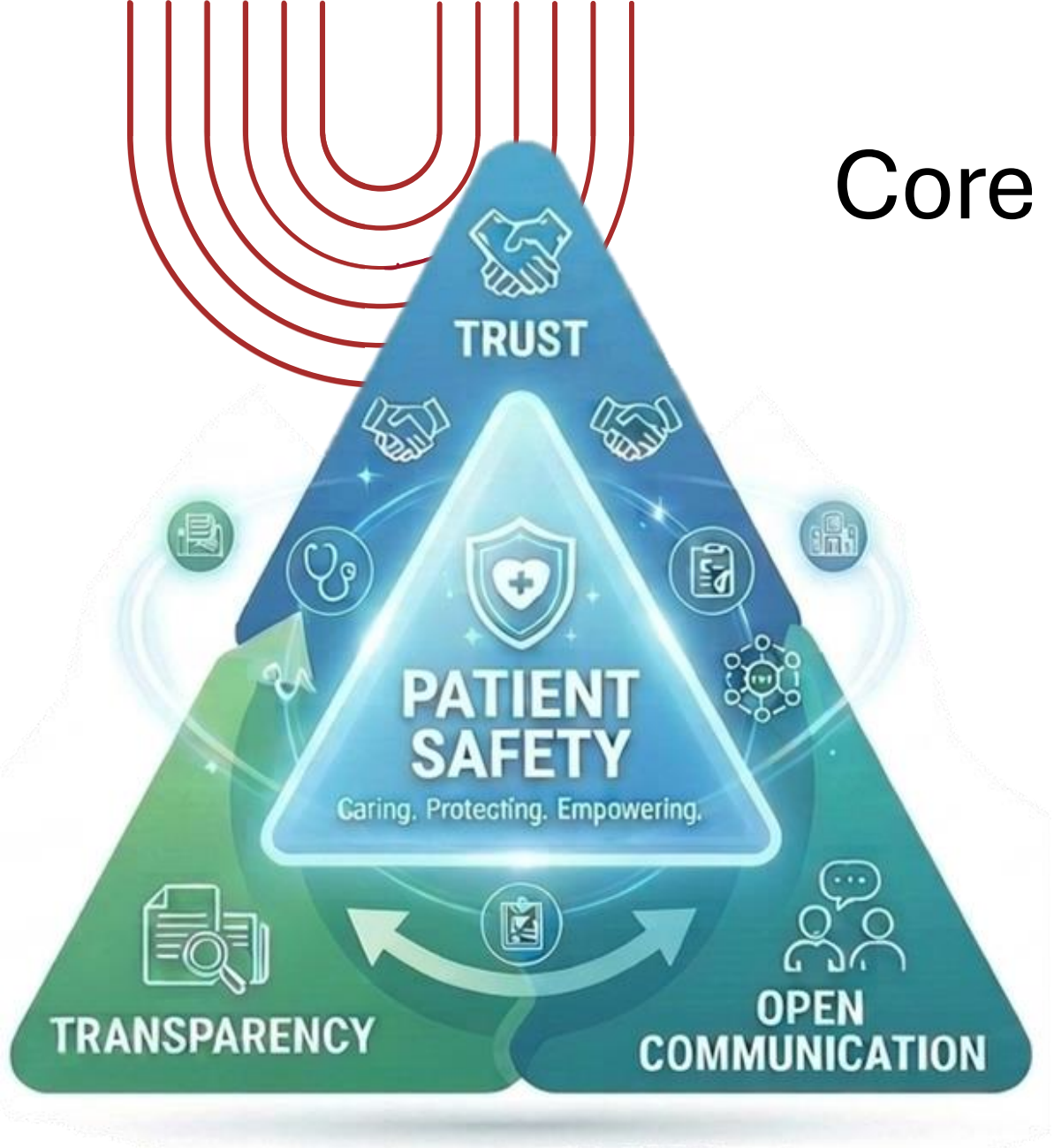
NYSCHP | New York State Council of Health-system Pharmacists



Core Principles of Just Culture

- **TRUST**
  - Reporting without fear
  - Accountability standards
  - Focus on learning and system improvement

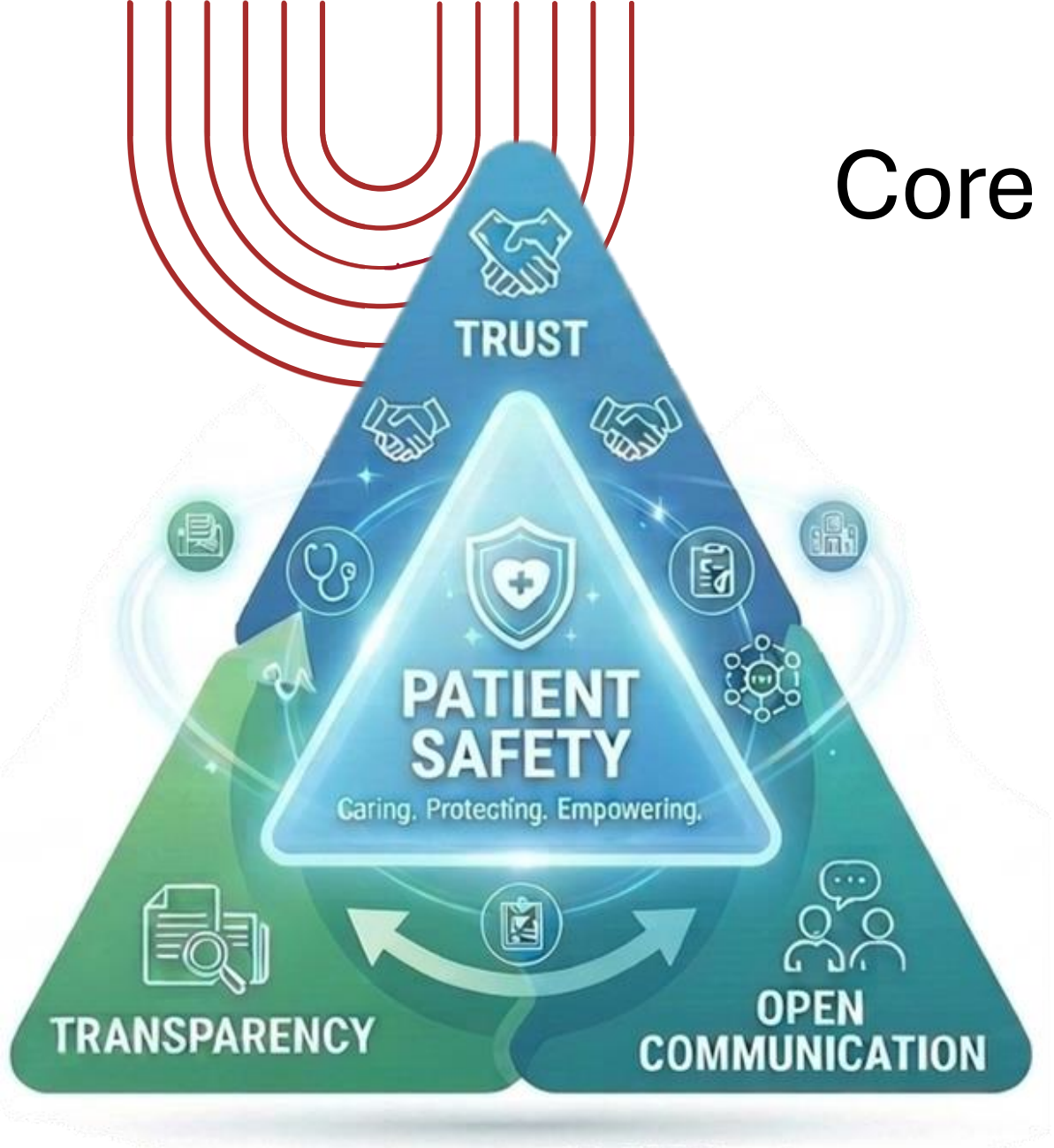
NYSCHP | New York State Council of Health-system Pharmacists



Core Principles of Just Culture

- **TRANSPARENCY**
  - Errors reported openly
  - Findings are shared
  - Communication of all action
  - Honest disclosure

NYSCHP | New York State Council of Health-system Pharmacists



Core Principles of Just Culture

- **OPEN COMMUNICATION**
  - Psychologically safe
  - Leaders actively listen
  - Lessons are discussed
  - Feedback is valued

NYSCHP | New York State Council of Health-system Pharmacists

Why Just Culture Matters

- Learning Opportunities
- System Improvement
- Employee Reporting
- Identifying errors prevents future harm

NYSCHP | New York State Council of Health-system Pharmacists

Error Reporting Saves Lives

- **Near misses**
  - No patient harm
  - Fix faulty processes
  - Identify dangerous trends
- **Improvements**
  - Barcode Scanning
  - Standardization
  - Medication Labels

NYSCHP | New York State Council of Health-system Pharmacists

When Just Culture Fails

NYSCHP | New York State Council of Health-system Pharmacists

Loss of Communication

Saturday, June 5th 2025

Nurse claims hospital gave babies to wrong parents – then fired her for exposing the mistake

- Mistakes may jeopardize employment
- Less willing to report errors
- Repeated mistakes
- Adverse patient outcomes

NYSCHP | New York State Council of Health-system Pharmacists

Loss of Transparency


day, July 5th, 2024

Pharmacy Tech Fired for Dispensing Errors

- Focus shifted to individual
- Missed opportunity to identify faulty process
- Employees feel excluded

NYSCHP | New York State Council of Health-system Pharmacists

Loss of Trust

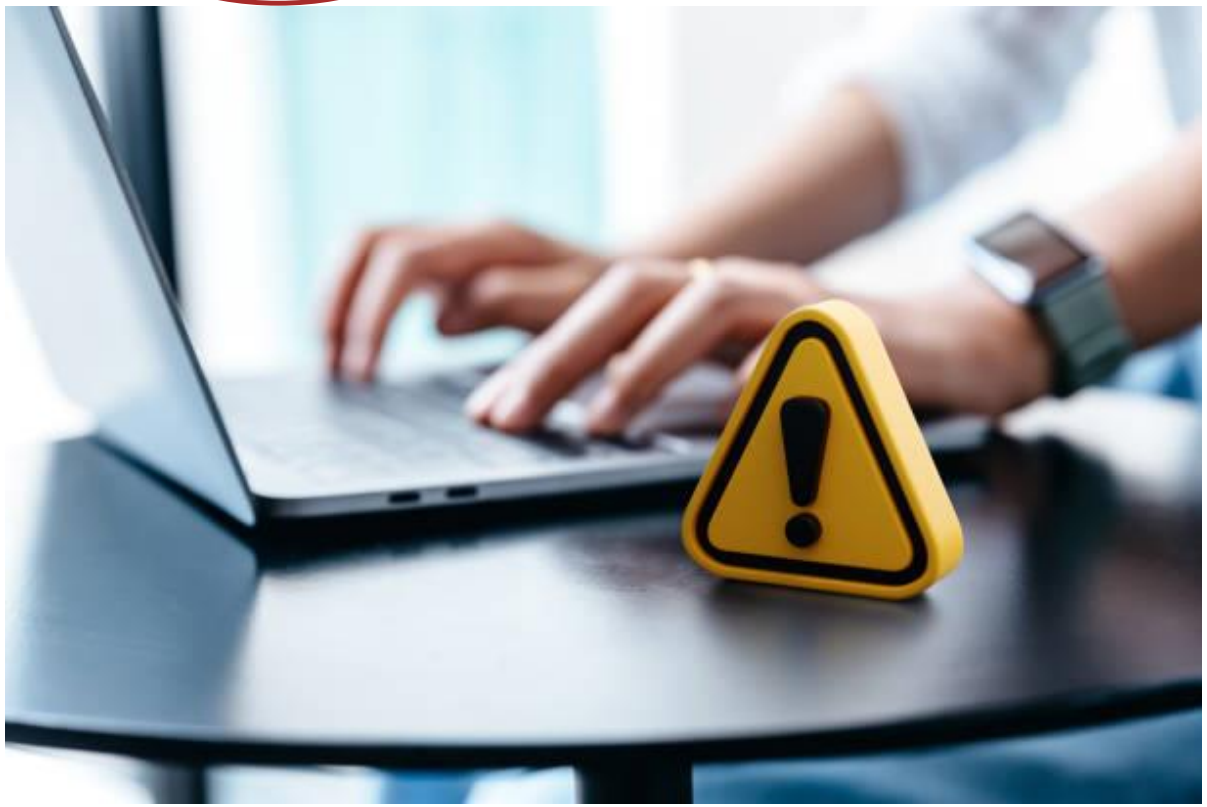

THE DAILY NEWS

Sunday, December 24th, 2017

As a nurse faces prison for a deadly error, her colleagues worry: Could I be next?

- Will my organization support me in the event of an error?
- Trust is difficult to build, but easy to lose

Human Error is Inevitable



- Distractions
- Fatigue
- Memory
- HUMAN

NYSCHP | New York State Council of Health-system Pharmacists

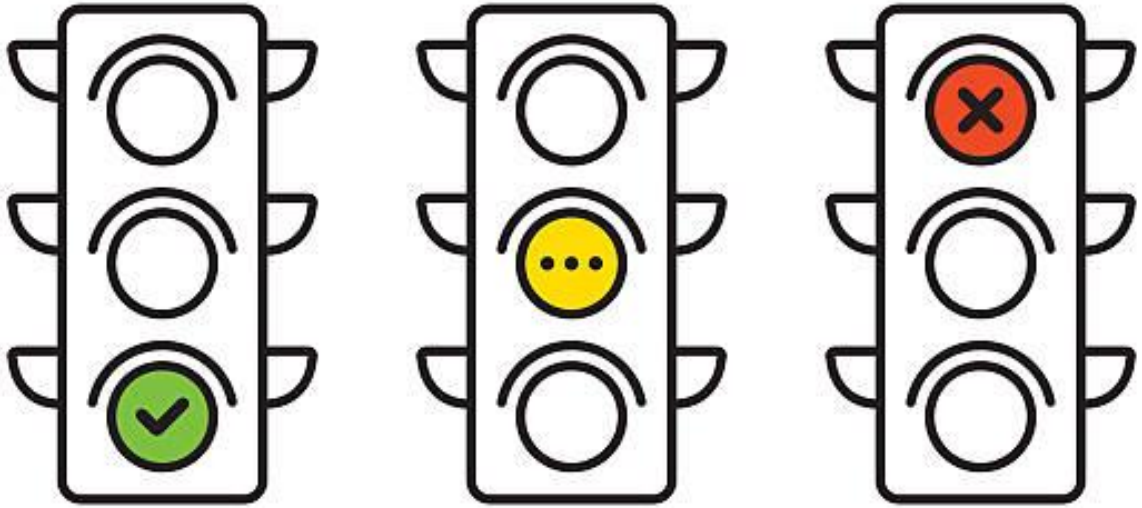
Task Switching and Healthcare

- **Healthcare workers often operate in environments filled with constant interruptions**
  - Questions
  - Phone calls
  - Alerts
  - Documentation

NYSCHP | New York State Council of Health-system Pharmacists

Three Types of Behavior

- Human Error
- At-Risk Behavior
- Reckless Behavior



NYSCHP | New York State Council of Health-system Pharmacists

Human Error

- **Behavior**
  - Unintentional
  - Inevitable
- **Response**
  - Support
  - Empathy
  - Understanding

NYSCHP | New York State Council of Health-system Pharmacists

At-Risk Behavior

- **Behavior**
  - Intentional
  - Use of shortcuts
  - Use of work-arounds
- **Response**
  - Education
  - Coaching

NYSCHP | New York State Council of Health-system Pharmacists

Reckless Behavior

- **Behavior**
  - Intentional
  - Disregard risk
- **Response**
  - Disciplinary action

Accountability Reimagined

- OWNERSHIP
- Taking Responsibility
- Helping Repair Harm
- Participating in Improvement Efforts

NYSCHP | New York State Council of Health-system Pharmacists

Organizational Accountability

- **Workflow design**
  - Communication
  - Coordination
  - Technology
  - Staffing models
  - Training

Why Errors Go Unreported

- **Barriers**
  - FEAR
  - Time Constraints
  - Lack of Resources
  - Insufficient Training

NYSCHP | New York State Council of Health-system Pharmacists

Fear and Reporting

- **FEAR**
  - Disciplinary action
  - Loss of employment
  - Legal consequences
  - Judgement
  - Damage to reputation

Reporting Systems as a Barrier

- Complex
- Time-Consuming
- Difficult to navigate

NYSCHP | New York State Council of Health-system Pharmacists

The Second Victim

- Internalize responsibility
- Self-Blame
- Guilt
- Shame
- Anxiety
- Overwhelming stress
- Loss of confidence
- Workforce attrition

NYSCHP | New York State Council of Health-system Pharmacists

Recovery After an Error

- Initial shock
- Repeated reflection
- Questioning competence
- Fear of consequences
- Seeking emotional support
- Eventually moving forward

NYSCHP | New York State Council of Health-system Pharmacists

Building a Better Just Culture

- Visible and Approachable Leaders
- Effective Reporting Systems
- Psychologically Safe Environment
- Support Systems
- Meaningful Action

NYSCHP | New York State Council of Health-system Pharmacists

What Healthcare Professionals Can Do

- Report errors
- Report near misses
- Support coworkers
- Avoid UNSAFE shortcuts
- Safety discussions
- PRIDE in ACCOUNTABILITY

Every report represents an opportunity to improve patient care!!

NYSCHP | New York State Council of Health-system Pharmacists

Key Takeaways

- Human Error is **INEVITABLE**
- Accountability should be fair and shared
- Patient safety improves when people speak up

NYSCHP | New York State Council of Health-system Pharmacists

Closing Slide

- **Make a commitment**
  - Transparency over silence
  - Improvement over complacency

NYSCHP | New York State Council of Health-system Pharmacists

References

- Kreckler, S., Catchpole, K., McCulloch, P., & Handa, A. (2009). Factors influencing incident reporting in surgical care. *Quality and Safety in Health Care*, *18*(2), 116–120.
- Jensen L.S., Merry, A.F., Webster, C.S., et al. (2004). Evidence-based Strategies for Preventing Drug Administration Errors during Anaesthesia. *Anaesthesia*, 59, 493-504.
- Goeschel, C. (2011). Defining and Assigning Accountability for Quality Care and Patient Safety. *Journal of Nursing Regulation*, 2(1).
- Helo S., Moulton, C. (2017). Complications: Acknowledging, Managing, and Coping with Human Error. *Translational Andrology and Urology*, 6(4), 773-782.
- Aljabari, S., Kadhim, Z. (2021). Common Barriers to Reporting Medical Errors. The Scientific World Journal. Article ID 649889.
- L. T. Kohn, J. Corrigan, and M. S. Donaldson, To Err is Human: Building a Safer Health System, National Academies Press (US), Washington, DC, USA, 2000.
- J. T. James, “A new, evidence-based estimate of patient harms associated with hospital care,” Journal of Patient Safety, vol. 9, no. 3, pp. 122–128, 2013.
- B. M. Hammoudi and O. A. Yahya, “Factors associated with medication administration errors and why nurses fail to re port them,” Scandinavian Journal of Caring Sciences, vol. 32, no. 3, pp. 1038–1046, 2017.
- H.-J. Kang, H. Park, J. M. Oh, and E.-K. Lee, “Perception of reporting medication errors including near-misses among Korean hospital pharmacists,” Medicine (Baltimore), vol. 96, no. 39, Article ID e7795, 2017.
- H. F. Dirik, M. Samur, S. S. Intepeler, and A. Hewison, “Nurses’ identification and reporting of medication errors,” Journal of Clinical Nursing, vol. 28, no. 5-6, pp. 931–938, 2019.
- Nembhard IM, Edmondson AC. Making it safe: the effects of leader inclusiveness and professional status on psychological safety and improvement efforts in health care teams. J Organ Behav 2006; 27: 94166.
- Wahr J.A., Prager, R.L., Abernathy J.H., et al. Patient Safety in the Cardiac operating room: human factors and teamwork: a scientific statement from the American Heart Association. Circulation.2013;128:1139-1169.
- Anderson JE, Kodate N, Walters R, Dodds A. Can incident reporting improve safety? Healthcare practitioners' views of the effectiveness of incident reporting. International J Qual Health Care. 2013;25(2):141-150.
- Yung H, Yu S, Chu C, Hou I, Tang F. Nurses' attitudes and perceived barriers to the reporting of medication administration errors. J Nurs Manag. 2016;24(5):580-588.
- Ridley CH, Al-Hammadi N, Maniar HS, et al. Building a Collaborative Culture: focus on Psychological Safety and Error Reporting. Ann Thorac Surg. 2021;111(2):683–689.
- Chegini Z, Kakemam E, Asghari Jafarabadi M, Janati A. The impact of patient safety culture and the leader coaching behaviour of nurses on the intention to report errors: a cross-sectional survey. BMC Nurs. 2020;19:89.

References

- Brubacher JR, Hunte GS, Hamilton L, Taylor A. Barriers to and incentives for safety event reporting in emergency departments. Healthc Q. 2011;14(3):57-65.
- Poorolajal J, Rezaie S, Aghighi N. Barriers to medical error reporting. Int J Prev Med. 2015;6:97.
- Kim JE, Kang MA, An KE, Sung YH. A survey of nurses' perception of patient safety related to hospital culture and reports of medical errors. Clin Nurs Res. 2007;13(3):169-179.
- Kim M. The effectiveness of error reporting promoting strategy on nurse's attitude, patient safety culture, intention to report and reporting rate. J Korean Acad Nurs. 2010;40(2):172-181.
- Eng, D., Schweikart S. Why Accountability Sharing in Health Care Organizational Cultures Means Patients are Probably Safer. AMA J Ethics. 2020;22(9):E779-783.
- Centers for Medicare and Medicaid Services, US Department of Health and Human Services. Statement of deficiencies and plan of correction: Vanderbilt University Medical Center. lOMB 0938-0391.
- Shelton C. Investigation: former Vandy nurse admits she “f----d” up, multiple overrides lead to death. Fox 17 Nashville. March 27, 2019.
- Glas G. A normative practice approach to healthcare. In: de Vries MJ, Jochemsen H, editors. The Normative Nature of Social Practices and Ethics in Professional Environments. Hershey (USA): IGI Global; 2019. p. 164–84.
- Peteet JR, Witvliet CVO, Evans CS. Accountability as a key virtue in mental health and human flourishing. Philos Psychiatry Psychol. 2022;29(1):49–60.
- Matthews SC, Demski R, Pronovost PJ. Redefining accountability in quality and safety at academic medical centers. Q Manage Health Care. 2016;25(4):244–7.
- Pronovost PJ. Learning accountability for patient out comes. JAMA. 2010;304(2):204-205.
- Griffith KS. Error prevention in a Just Culture: System design or human behavior? Jt Comm Perspect Patient Safety. 2010;10(6):10-11.
- Wu AW. Medical error: The second victim: The doctor who makes the mistake needs help too. BMJ. 2000;320:726-727.
- Weissman JS, Annas CL, Epstein AM, et al. Error report ing and disclosure systems: Views from hospital leaders. JAMA. 2005;293:1359-1366.
- White RM, Delacroix R. Second victim phenomenon: is ‘just culture’ a reality? An integrative review. Appl Nurs Res. 2020;56:151319.
- Hémon B, Michinov E, Guy D, Mancheron P, Scipion A. Speaking up about errors in routine clinical practice: a simulation-based intervention with nursing students. Clin Simulation Nursing. 2020;45:32–41.
- The Joint Commission, USA. The essential role of leadership in developing a safety culture. Sentinel Event Alert. 2017;12(57):1–8.
- Derickson R, Fishman J, Osatuke K, Teclaw R, Ramsel D. Psychological safety and error reporting within Veterans Health Administration hospitals. J Patient Saf. 2015;11(1):60–66.