

Interdisciplinary Medication Safety Panel

March 8, 2021

New York State Society of Health-system Pharmacists

Objectives

1. Define a Just Culture
2. Describe the differences between blame and accountability
3. Apply Just Culture concepts to the analysis of medication error examples
4. Explain how we can learn and improve patient safety following a medication error

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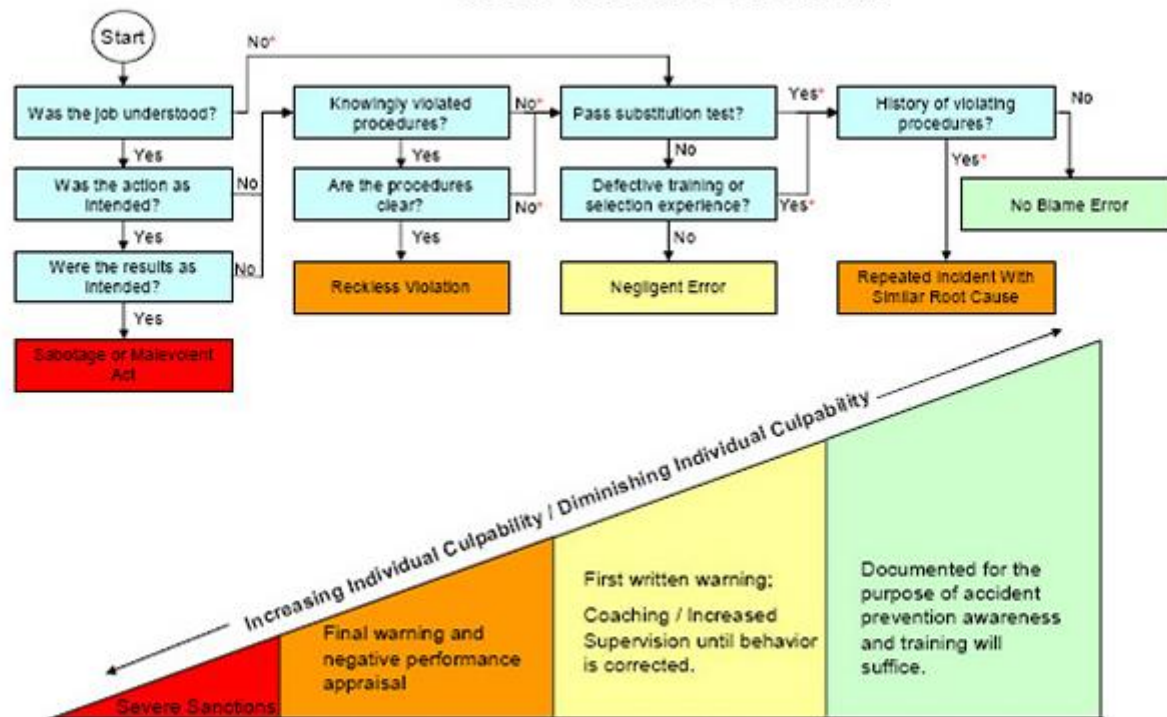


Question 1

What does a Just Culture mean in your organization?
How is it operationalized?

Just Culture Tool

Just Culture Process



* Indicates a 'System' induced error. Manager/supervisor must evaluate what part of the system failed and what corrective and preventative action is required. Corrective and preventative action shall be documented for management review.

Question 2

If you have implemented a Just Culture, and you see an increase in reporting of errors, does that reflect failure?

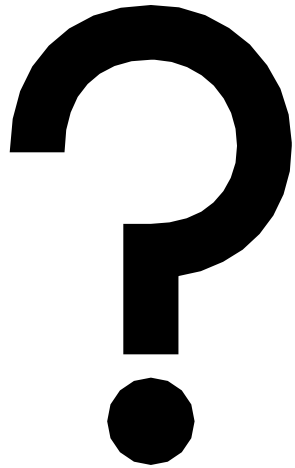
Question 3

Please define blame versus accountability. Could you provide an example or two when a healthcare worker was blamed versus held accountable?

Question 4

Can you please discuss the power of stopping the line?

What would you recommend practitioners do to feel empowered enough to stop the line?



Questions?