

Training Session for Policy Implementation

Learner's Name

Capella University

NHS6004: Health Care Law and Policy

Instructor Name

January 1, 2021

Training Session for Policy Implementation

Sound policy and practice guidelines for the management of medication errors are critical for a premier medical center such as Mercy Medical Center. For the successful implementation of the policy on managing medication errors, members of the nursing staff at the medical center who will be responsible for enacting the policy must thoroughly understand the strategies prescribed by the policy. A training program designed for staff members will ensure effective dissemination of the knowledge and skills required to implement the policy guidelines. The training program outlined in this paper will be conducted for a pilot group of 20 members of the nursing staff from the pediatric division of the medical center.

Promoting Nurses' Buy-In

According to Ruddy et al. (2016), for authentic transformation of medical practice technical changes are necessary but not sufficient. Systemic practice changes happen when those who practice are transformed. In a study by French-Bravo et al. (2020), nurses perceived that strong communicative relationships with nurse managers encouraged their buy-in to organizational initiatives. Nurse managers developed such strong relationships with nurses through multimodal approaches to communicating with nurses and influencing them. In addition to communicating information through email, huddles, and staff meetings, nurse managers communicated the rationale for change using data in the form of statistics, facts, and patient feedback comments. Nurse managers also served as role models to influence change, influenced the culture of units, and demonstrated characters such as approachableness and attentiveness to influence nurses. Nurse managers also facilitated change through management support and staff engagement through strategies such as making time to listen to nurses' concerns and supporting them as individuals and collectively as a team. A staff-led decision-making approach facilitated

by nurse managers involved helping staff understand unit goals, supporting them to drive the work of the unit, and increasing manager-facilitated peer communication (French-Bravo et al., 2020). Nurse managers, head nurses, and other members of nursing leadership will therefore play a crucial role in promoting buy-in of nurses to implement the policy and practice guidelines.

Early Indicators of Success

Three types of indicators can project the success of the policy at an early stage: structural indicators, process indicators, and outcome indicators. Structural indicators emphasize the quality of organizational aspects, for example, the availability and effective functioning of equipment such as automated dispensing cabinets. Process indicators focus on the process of care delivery. Efficiency in prescription management and in diagnosis management are two process indicators that measure the effectiveness of the policy. Outcome indicators are result oriented. Reduction in readmission rates, reduction in postsurgical wound infection rates, and patient experience are a few outcome indicators that can measure the success of the policy (Grol et al., 2013).

Nurses' perceptions about automated dispensing cabinets are important indicators of their readiness to implement the practice guidelines (Metsämuuronen et al., 2020). Understanding their perceptions will help the center's management gauge the success of initiatives aimed at promoting buy-in. Survey questionnaires that include questions related to the change in policy and practice guidelines can be developed to measure nurses' perceptions about changes in their work environment (Norman & Sjetne, 2017).

Impact of Policy and Practice Guidelines

The policy on the management of medication errors states the procedure that must be followed in case of a medication error. The scope of the policy extends to the nursing,

emergency care, and medical staff employed at Mercy Medical Center (Black County Partnership, 2015). The policy requires that the medical center form a multidisciplinary committee. This committee will assess potential discrepancies and address shortfalls in medication processes (Weant et al., 2014).

Approaches to reduce medication errors include setting up a standardized medication error analysis system and implementation of automated dispensing cabinets. To set up a standardized medication error analysis system, the multidisciplinary committee should classify, prioritize, and regularize the process of reporting medication errors. Understanding the causes of medication errors through medication error analysis becomes simpler with the availability of accurate data. Automated dispensing cabinets are computerized systems for medicine management and are installed in health care units. These cabinets are used to manage errors that occur when dispensing medication. The cabinets store and dispense medication and electronically track drug inventory (Weant et al., 2014).

Impact of Policy Implementation on Nurses' Work

Medication errors are indicative of poor-quality health care services in a medical center. The proposed policy can prevent medication errors, ensure patient safety, help the medical center avoid litigation for medical negligence, prevent harm to the medical center's reputation, and reduce unnecessary expenses (Black County Partnership, 2015). A study by Bourcier et al. (2016), indicated that implementation of automated dispensing cabinets dramatically reduced the time that head nurses spent on weekly inventories and orders. This allowed nurses and head nurses to focus on their core responsibilities. The policy and guidelines change will increase the efficiency of the nursing staff by decreasing the effort and time spent on medication procedures, which will increase the job satisfaction of the members of the nursing staff.

Concerns Over the Policy

The pilot group selected will be trained on the two strategies: installation and use of automated dispensing cabinets and standardized medication error analysis. Staff members could be apprehensive about reporting errors considering the degree of fatality of the error and the disciplinary action as a consequence of underreporting (Chu, 2016). Such apprehension may cause the nursing staff to object to the establishment of a standardized system for medication error analysis. Implementation of the second strategy, installation of automated dispensing cabinets, would be beneficial for medication management and prevention of errors; however, automated dispensing cabinets can potentially cause errors in the retrieval of medication in case of mismanagement of medical inventory (Weant et al., 2014). This could be a potential concern for the nursing staff.

Interpreting the Policy for Nursing Staff

One of the complexities of implementing the strategies of the policy is deciding to report an event as a medication error. The lack of standard definitions for medication errors leads to unidentified errors because there is uncertainty around whether an error needs to be reported. The implementation of a standardized system for medication error analysis would require that medication errors be clearly defined. This would help nurses identify medication errors accurately and report them (Chu, 2016).

The number of medication errors in Mercy Medical Centre's medical and surgical units increased by 50% from 2015 to 2016. Most medication errors occur during medication administration by nursing staff (Ofusu & Jarrett, 2015). The training program on policy implementation, therefore, intends to familiarize the nursing staff with complex sections of the policy such as the repercussions of negligence and the protocol to be followed while addressing

medication errors. The nursing staff will also be clearly informed of the chain of command for the purpose of reporting errors.

Importance of Policy and Practice Guidelines in Nurses' Work

Improved management of medication errors could reduce stress and improve work satisfaction for nurses. A study by Metsämuuronen et al. (2020) assessed perceptions of nurses in an observational study and an online survey to find that nurses believed that automated dispensing cabinets would make their work easier. The nurses were able to save time and focus on direct patient care activities. Another such study by Zaidan et al. (2016) has also indicated that nurses were satisfied with the implementation and believed that these systems were easy to use and helped them carry out their job safely.

Role of Nursing Staff in Policy Implementation

Nursing staff plays an important role in the implementation of a medication error management policy because of their proximity to patients and medication processes. A nurse is the last person involved in the administering of drugs. A nurse is responsible for physically administering the right drug to a patient and can therefore easily identify and correct any error in the medication process (Ofusu & Jarrett, 2015). In order to ensure that the policy on managing medication errors is implemented efficiently, the nursing staff must focus on maintaining accuracy and regularity in reporting medication errors. The nursing staff can prevent errors in drug administration by practicing the five rights: right dose, right patient, right time, right drug, and right route. The nursing staff can ensure that there are no medication errors while administering medication. Some ways the nursing staff can contribute positively toward policy implementation include calculating the amount of drugs accurately, reducing distractions while

administering medication, informing patients about the effects of a drug, and continuous revision of pharmacological knowledge (Chu, 2016).

Training Nursing Staff on the Policy

Nursing staff is involved in medication processes such as prescription and administration of medication. During drug administration, a nurse is the last person who may be able to rectify errors. While patient safety is a priority for nursing staff, they cause most medication errors because of constant distractions and interruptions in their work routine (Ofusu & Jarrett, 2015). It is important to train the nursing staff on the guidelines of the policy as inexperienced and untrained staff may not be able to anticipate or identify a medication error. The policy on managing medication errors requires that automated dispensing cabinets be set up and medication error analysis be performed. For the successful implementation of automated dispensing cabinets, it is crucial that the nursing staff be trained on the safe use of these devices. While automated dispensing cabinets are introduced to reduce errors, their incorrect usage can create problems in dispensing medication (Hamilton-Griffin, 2016). To implement the second strategy, namely medication error analysis, nursing staff must be trained on new procedures that will enable them to accurately and regularly report medication errors. Reinforcing the importance of reporting during training will encourage nurses to adopt the medication error reporting procedures, ensuring the availability of adequate data to perform a medication error analysis.

Training Process

A 2-hour workshop will be conducted to train the nursing staff on the use of automated dispensing cabinets and medication error analysis. A day before the training, a questionnaire will be circulated to the pilot group to assess their understanding of the two strategies. This workshop

will be divided into two sessions of an hour each. The first session will be conducted by *local opinion leaders*, who are individuals recognized as clinical experts in a specific field of medication. The opinion leaders will discuss the technical know-how required to operate automated dispensing cabinets and the steps that must be followed for medication error analysis. This session by local opinion leaders would have an influential impact on the nursing staff because of the presence of a familiar figure whose credentials are known.

The second session will involve simulation-based training. Here, the staff will participate in situations in which they have to operate automated dispensing cabinets and perform a mock medication error analysis. This session will give the staff real-world experience and provide insights into potential complexities they may encounter while using the automated dispensing cabinets or conducting a medication error analysis (Grol et al., 2013).

Training Material for Skill Development

Each participant will be given a handout containing the policy guidelines, a document listing the steps to follow while conducting a medication error analysis, and a user manual for the use of automated dispensing cabinets. In addition, a printed version of the content covered by the opinion leader will also be provided to the staff for future reference. In order to ensure continuous learning, the nursing staff will be given access to a virtual classroom using a log-in ID and password to access lectures and self-learning exercises (Grol et al., 2013). The handouts and the virtual learning material will be designed to help the staff members develop skills such as critical thinking and attention to detail and the confidence required to implement the strategies of the policy.

Conclusion

The policy on the management of medication errors was proposed by the leadership of Mercy Medical Center to reduce and prevent the occurrence of medication errors. For the successful implementation of the policy, it is essential to design a training program for the hospital staff on the various strategies of the policy. The program will help staff members understand the importance of managing medication errors, thereby improving patient safety, the medical center's reputation, and the staff's job satisfaction.

References

- Black County Partnership, NHS Foundation Trust. (2015). *Medication error policy*.
<https://www.bcpft.nhs.uk/documents/policies/m/973-medication-errors/file>
- Bourcier, E., Madelaine, S., Archer, V., Kramp, F., Paul, M., & Astier, A. (2016).
 Implementation of automated dispensing cabinets for management of medical devices in
 an intensive care unit: Organisational and financial impact. *European Journal of Hospital
 Pharmacy*, 23(2), 86–90. <https://europepmc.org/article/pmc/6451497>
- Chu, R. Z. (2016). Simple steps to reduce medication errors. *Nursing 2016*, 46(8), 63–65.
<https://doi.org/10.1097/01.nurse.0000484977.05034.9c>
- Grol, R., Wensing, M., Eccles, M., & Davis, D. (2013). *Improving patient care: The
 implementation of change in health care*. [https://ebookcentral-proquest-
 com.library.capella.edu/lib/capella/reader.action?docID=1153537](https://ebookcentral-proquest-com.library.capella.edu/lib/capella/reader.action?docID=1153537)
- Hamilton-Griffin, K. (2016). *Developing improvement strategies on the use of automated
 dispensing cabinets to reduce medication errors in a hospital setting* (Doctoral
 dissertation). ProQuest. (Order No. 10127834)
- French-Bravo, M., Nelson-Brantley, H. V., Williams, K., Ford, D. J., Manos, L., & Veazey
 Brooks, J. (2020). Exploring nurses' perceptions of nurse managers' communicative
 relationships that encourage nurses' decisions to buy-in to initiatives that enhance
 patients' experiences with care. *Journal of Nursing Management*, 28(3), 567– 576.
<https://doi-org.library.capella.edu/10.1111/jonm.12958>
- Metsämuuronen, R., Kokki, H., Naaranlahti, T., Kurttila, M., & Heikkilä, R. (2020). Nurses'`
 perceptions of automated dispensing cabinets — an observational study and an online
 survey. *BMC Nursing*, 19, 1-9. <https://doi.org/10.1186/s12912-020-00420-2>

- Norman, R. M., & Sjetne, I. S. (2017). Measuring nurses' perception of work environment: A scoping review of questionnaires. *BMC Nursing, 16*(1), 66.
<https://doi.org/10.1186/s12912-017-0256-9>
- Ofusu, R., & Jarrett, P. (2015). Reducing nurse medicine administration errors. *Nursing Times, 111*(20), 12–14.
https://www.nursingtimes.net/Journals/2015/05/10/t/1/q/130515_Reducing-nurse-medicine-administration-errors.pdf
- Ruddy, M. P., Thomas-Hemak, L. & Meade, L. (2016). Practice Transformation. *Academic Medicine, 91*(5), 624–627. <https://doi.org/10.1097/ACM.0000000000001059>
- Weant, K. A., Bailey, A. M., & Baker, S. N. (2014). Strategies for reducing medication errors in the emergency department. *Open Access Emergency Medicine, 6*, 45–55.
<https://doi.org/10.2147/OAEM.S64174>
- Zaidan, M., Rustom, F., Kassem, N., Al Yafei, S., Peters, L., & Ibrahim, M. I. M. (2016). Nurses' perceptions of and satisfaction with the use of automated dispensing cabinets at the Heart and Cancer Centers in Qatar: a cross-sectional study. *BMC nursing, 15*(1), 4.
<https://doi.org/10.1186/s12912-015-0121-7>