Week 5: Organizational Culture and Climate on Group Process and Team Building

You are the unit director of the emergency department and part of an ad hoc interdisciplinary committee newly formed to address a rise in system-wide medication errors. The task for the committee is to find the root cause of the increase in errors and propose solution for the problem.

Who are the stakeholders represented in the group?

Discuss the difference between organizational culture and climate and the impact of each on transparency and safety during the group's process and team building. Include their impact on the outcomes of the committee as well.

What are some different ways that you measure climate in your organization?

References

Who are the stakeholders represented in the group?

In this week's discussion scenario, the group's stakeholders are the leadership team, pharmacy, executive team of the organization, physicians, nurses, and team members. Marquis & Huston 2017 define stakeholders as bodies with the organization's background responsible for the wellbeing and functions that influence the organization. These are considered internal stakeholders, as they are interested in the reputation and vitality of the organization. External stakeholders are investors who may have financial interests but no decision-making authority, patients, families, and the communities, that depend on the

organization for healthcare needs.

Medication errors can cause serious sentinel events to the patients providing care. Spruce 2020 shares the Institute of Medicine's report To Err Is Human: Building a Safer Health System in November of 1999, 98,000 yearly deaths are related to mistakes made by people working in healthcare. Medication errors accounted for 563 (7.9%) of the 7,288 patients, which The Joint Commission reviewed from the 7,147 sentinel events from 1995 to 2010. Therefore, RCA's root cause analysis to find why medication errors are rising is essential for its health. The above committee will then develop a strategic plan, preventing the mistakes to reoccur.

Discuss the difference between organizational culture and climate and the impact of each on transparency and safety during the group's process and team building. Include their impact on the outcomes of the committee as well.

The philosophy of an organization defines an organization's missions and values, which formals goals to meet the standards of their beliefs. Based on this belief, the organization describes characteristics, implements standards, policies, and procedures for their employees and leadership to represent their organization. Climate culture then is the way those employees believe that the organizations' environment appears.

When building a team, it is vital to be clear and concise on why the group, the goals, outcomes, and responsibilities. When creating a team, it is essential to understand each individual's different cultures and think of its culture to meet the team's goals. Understanding that individuals are part of the group come from different cultures, mutual respect of their background differences is acknowledged. The team then functions together to investigate the error's reasons and then develop a plan creating new policies and procedures, preventing the same mistakes.

An organization that practices honesty, trustworthy and non-blaming environment creates a culture of speaking up when there is a mistake. Nurses should be involved in developing and forming safe practices involving their profession. When an error occurs, it is the lesson to learn when organizations create a safe environment assisting in intervention development that prevents the same mistake. Dang & Dearholt, 2017 shared Johns Hopkins Nursing Evidence-Based Practice Model (JHNEBP), developed in 2007 by Newhouse, Dearholt, Poe, Pugh, & White, to help nurses foster and improve standards procedures and interventions to enrich evidence-based practice. JHNEBP is a problem-solving process to medical policymaking by using a three-step method called PET: practice question, evidence, and translation to find the most up-to-date research findings and best practices to implement into patient care interventions.

Thank you for your response. Lauren and group, what system is your organization using, or how is your organization assisting staff in reporting errors or incidents?

My organization uses Epic computerized documentation, and we were allowed to choose the name for the incident reporting system we call Safer Report. There are multiple categories once you enter the system, and you generate the report based on what type or location/area of the hospital you work. For instance, I work in surgery, and most of my reporting goes under Surgery/Procedure. The information generates to the department's director, risk management, and others included as necessary when adding names of interest to the report.