Edited by
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Nursing Pathways *for* Patient Safety

NCSBN
National Council of State Boards of Nursing

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Nursing Pathways *for* Patient Safety

National Council of State Boards of Nursing (NCSBN)
Expert Panel on Practice Breakdown

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FOREWORD

I have always said that the most significant work of the National Council of State Boards of Nursing, Inc. (NCSBN®) starts with a good question. Inevitably, the strategic initiatives of the NCSBN that have the greatest impact in the public protection arena begin with a simple but profound question. The question for this book emerged from a discussion of the discipline function at state boards of nursing. All state boards of nursing in their public protection mandate must ensure that nurses are safe and competent to practice at the time of initial licensure and throughout their entire career in order to protect the consumer. When evidence of substandard nursing practice demonstrates a clear violation of state law or the Nurse Practice Act, boards of nursing are mandated to take action through administrative procedures that result in discipline of the nurse. The process is reactive; the challenge exists in making it a more proactive.

How can state boards of nursing be proactive and prevent unsafe practice? If this question is answered, patient safety would be improved. Additionally, prevention of unsafe practice decreases the need for the disciplinary administrative process, which typically accounts for the largest portion of a board of nursing's annual budget.

So what do we know about nursing practice that results in disciplinary action? We certainly know a fair amount about the disciplinary process, since this is an integral function of any health care licensing board. We have data on the types of disciplinary actions taken and a general idea of what brings nursing practice to the attention of the state board of nursing. What we had not studied was the phenomenon of what happens when nursing practice breaks down from both a system and an individual point of view.

The NCSBN is an organization founded by state boards of nursing to decrease government burdens. It does this by providing an organization through which boards of nursing act on matters of common interest and concern affecting the public health, safety, and welfare. A mainstay of this organization is the creation of committees composed of board of nursing staff as well as nurses and other experts appointed to serve the boards.

These committees convene to research regulatory issues, develop regulatory models, create position papers, and provide the analysis that forms the foundation for evidenced-based regulatory decisions.

Since 2002 the mission of the NCSBN has been rooted in the concept of regulatory excellence and its advancement. State boards of nursing recognize that good solid data are needed to create effective public policy and further the evolution of nursing practice regulation.

In 2002 the Practice Breakdown Research Advisory Panel was created to develop a collection instrument that would extract data from disciplinary cases. The data collected would record the incident, the individual nurse involved, and the system in which the incident occurred. The NCSBN invited experts to participate in this process and was honored to have Dr. Patricia Benner, Dr. Kathy Scott, and Dr. Marie Farrell as participants along with members from state boards of nursing and NCSBN staff. The work of the Advisory Panel

clearly aligned with the strategic direction of the organization regarding regulatory excellence.

Taxonomy of Error, Root Cause Analysis, and Practice Responsibility (TERCAP®) was launched in February 2007 as a secure and comprehensive online intake instrument designed for nursing boards to use prospectively in cases involving practice breakdown. Study questions from this book will be used to analyze the aggregate data that nursing boards will report to the NCSBN.

This book and the work it represents have had the complete support of the Board of Directors and NCSBN staff throughout the entire process. As the executive director of the NCSBN, I knew from the beginning that the potential of this project would have a dramatic impact on patient safety in this country. The data collected from the use of the TERCAP instrument and resulting analysis will provide critical patient safety improvement information, the likes of which have not been seen in other studies.

George Bernard Shaw said, "No question is so difficult to answer as that to which the answer is obvious." This book answers the question, and in the future TERCAP will continue to uncover data that will contribute to the improvement of nursing practices and the protection of the public.

Kathy Apple, MS, RN, CAE
Chief Executive Officer
National Council of State Boards of Nursing

PREFACE

The goal of this work is to better understand and articulate the role of nurses, health care institutions, working conditions, and education on patient safety. Nurses are the last possible point of preventing errors in health care because they are the ones to monitor patients and deliver most therapies. Some areas of patient safety receive more emphasis, such as medication error and surgical mishaps, yet focus on these two areas of patient safety cause the public to overlook large areas of patient safety, such as lack of prevention of hazards of immobility and hospitalization, and errors related to patient vulnerabilities, such as cognitive impairment, allergies, and physical limitations. The state boards of nursing identified a need for broadening the focus on patient safety and on the role of nurses in patient safety.

This is a landmark work of the NCSBN to communicate recent changes in investigatory tools, including a taxonomy of standards of nursing practice that are at the frontline of patient safety work. The impetus for this work was to delineate the very general and broad category of professional nursing actions and judgments into distinct functions, goals, and notions of good internal to nursing practice. All professional nursing actions might be considered to be based on good judgment and the standards of good nursing practice, but distinct aspects of frontline nursing aims, such as preventing the hazards of immobility and safety risks due to hospitalization, are attended to primarily by nurses. Even the safety measures instituted for other professional workers are monitored and maintained by nurses. The impetus for this work was also to respond to the Institute of Medicine reports on patient safety (Kohn, L.T., Corrigan, J.M., & Donaldson, M.S., 2000) by developing more standardized investigatory categories that incorporate systems issues, including environmental issues, team functioning, staffing, a nurse's work patterns, as well as the usual focus on the professional nurse's narrative account of the reported incident and an assessment of responsibility and accountability in a particular incident of practice breakdown. The goal is to develop a national database of nursing errors/practice breakdown reported to state boards of nursing in order to improve the prevention of errors, and increase the research base for disciplinary and educational strategies to improve patient safety on the part of nurses. A secondary goal is to make the TERCAP tool of describing nursing practice breakdown available to hospitals and other health care institutions.

We believe that this work will help nurses and student nurses improve their practice and better understand the kinds of practice breakdown incidents that might be reported to the state boards of nursing. The focus of the book is on the broad dimensions of patient safety work that have always been central to the nursing role, since nurses are at the sharp end of practice (Kohn et al., 2000) and the patient's last line of defense for the prevention of errors. These broad categories will be explicated and illustrated throughout the book as follows: (1) *Safe Medication Administration*: The nurse administers the right dose of the right medication via the right route to the right patient at the right time for the right reason. (2) *Documentation*: Nursing documentation provides

relevant information about the patient and the measures implemented in response to their needs. (3) *Attentiveness/Surveillance*: The nurse monitors what is happening with the patient and staff. The nurse observes the patient's clinical condition. If the nurse has not observed a patient, then he/she cannot identify changes if they have occurred and/or make knowledgeable discernments and decisions about the patient's condition or care. (4) *Clinical Reasoning*: Nurses interpret patients' signs, symptoms, and responses to therapies. Nurses evaluate the relevance of changes in patients' signs and symptoms and ensure that patient care providers are notified and that patient care is adjusted appropriately. (5) *Prevention*: The nurse follows usual and customary measures to prevent risks, hazards, or complications due to illness or hospitalization. These include taking precautions to prevent falls and preventing the hazards of immobility, contractures, or stasis pneumonia, and more. (6) *Intervention*: The nurse properly executes nursing interventions. (7) *Interpretation of Authorized Provider Orders*: The nurse interprets authorized provider orders. (8) *Professional Responsibility/Patient Advocacy*: The nurse demonstrates professional responsibility and understands the nature of the nurse-patient relationship. Advocacy refers to the expectations that nurses act responsibly in protecting patient/family vulnerabilities and in advocating to see that patient needs/concerns are addressed.

At the heart of the work is the view that, ultimately, a narrow focus on discrete "errors" will not improve patient safety systems and nurse practice environments. In most cases it is a combination of practice styles, environments, teamwork, and structural systems that contribute to practice breakdown, a term used throughout this book instead of "mistakes" or the identification of single end points in error events.

Health care institutions are complex institutions that require professional knowledge workers who work in teams in legally bounded areas of responsibility for patient care (Sullivan, 2004; Benner & Sullivan, 2005). Rules, procedures, policies, and systems approaches to error prevention are essential but not sufficient for the daily practice of professionals who assume ethical and fiduciary responsibility for the prevention of harm, safe health care delivery, and facilitation of beneficial care toward the care and recovery of patients.

The work of nursing regulation is challenged, contentious, and resisted. Yet the need for an effective oversight process for patient safety and nurse competence has never been greater. The challenges of supply, demand, allocation of funding, role evolution, technology, and computerization advances and unprecedented consumerism have made the work of the NCSBN Practice Breakdown Advisory Panel (PBAP) not only an imperative for patient care quality but also a labor of love for panel members.

We created this book with the following goals in mind:

1. To transform the management of discipline using an evidence-based approach.
2. To provide objective and measurable insight into the practice of nursing as related to breakdown.
3. To provide a data collection instrument for nurse regulators, practitioners, and educators to assess and report consistently and objectively practice breakdown.

4. To begin to build a national repository of data that would better inform nursing practice and the solutions to improved and safer practice
5. To develop a taxonomy of nursing errors to better understand and articulate the nurse's role in patient safety.
6. To inform nurses, nurse educators and nursing students, patient safety managers, and policy makers about the types of errors reported to state boards of nursing and the disciplinary investigation processes related to those errors.

Creating this work has evolved much like an action research project—that is, as each phase was completed, new information became available and the next phase was launched. The PBAP began with the need to provide better informed discipline-specific decisions at the state level and ultimately produced a highly valid and reliable data collection instrument, the Taxonomy of Error, Root Cause Analysis, and Practice Responsibility (TERCAP®). This instrument is now available in electronic format to all boards of nursing in the United States and NCSBN territories. The term "root cause" is used in the title because the categories from a full root cause of analysis were used in the design of the instrument. The authors are clear that a survey including the categories usually covered in a root cause analysis is not the same, nor is a survey a replacement for the more lengthy local process of conducting an institutional root cause analysis. But as a survey instrument, used within a particular institution, the categories on the survey can be used for a statistical survey and compared to actual full-scale root cause analyses (Bagian, Gosbee, Lee, et al., 2002; Rex, Turnbull, Allen, et al., 2000; Chassin & Becher, 2002).

This book is organized to present the TERCAP and begins with an introduction to the years of work that informed its current format and content. Each of the TERCAP practice breakdown chapters is discussed in detail with definitions, explanations, and case examples. The book shows the ways in which the major elements of a framework evolved from a study of cases, and it ends with a brief summary of accomplishments and the panel's vision of the next steps needed to ensure a sound way forward to prevent practice breakdown in the health care workplace.

Kathy Malloch
Chairperson
NCSBN Expert Panel on Practice Breakdown

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Kathy Malloch
Chairperson
NCSBN Expert Panel on Practice Breakdown

CONTENTS

1

Overview: NCSBN Practice Breakdown Initiative

Kathy Malloch ◆ Patricia Benner ◆ Vickie Sheets ◆ Kevin Kenward ◆ Marie Farrell

Chapter Outline

Everyone can recall lessons learned from experience. Often the best remembered lessons are the ones that were hardest learned—gleaned from making mistakes and dealing with the fallout from those mistakes. By studying situations where nursing practice breaks down, nurses can learn from the experiences of their colleagues. This is far better than learning from reliving the same difficult experiences ***(Author Unknown)****.*

Each day, in most health care settings in the United States, nurses monitor and manage the health care patients receive. The goal of these efforts is to ensure that the health care team delivers high-quality and safe patient care. Despite these efforts, missteps occur as do undetected changes in patients' conditions. These missteps and undetected changes are cause for great concern, and they challenge caregivers to examine their practices, and to create safer practices and ultimately better patient outcomes. The traditional, punitive, blame-placing practices that are found in most health care organizations also give cause for great concern, as those involved in these missteps are often reluctant to report them.

For these reasons (and others described below), the National Council of State Boards of Nursing (NCSBN) launched a national initiative in 1999 entitled the Practice Breakdown Advisory Panel (PBAP). The objective of the PBAP was to study nursing practice breakdown, to identify common themes related to those events, and most importantly, to recommend strategies to individuals, teams,

and organizations to correct unsafe conditions and practices. This work would then assist boards of nursing to shift the focus from blame and punishment to prevention, remediation, and correction. Punishment would be limited to those cases of willful negligence and misconduct.

Since its inception, the PBAB has worked with representatives from its 60 member boards and with its consultant, Dr. Patricia Benner, to develop an initial minimum data set on practice breakdown reported to state boards of nursing. The goal was to develop an instrument that can distinguish human and system errors from willful negligence and intentional misconduct, while identifying the area of actual nursing practice breakdown in relation to core goals and standards of good nursing practice. An additional and equally important aim was to serve as a guide to increase the skills and competence of regulatory professionals in addressing practice breakdowns.

GOALS OF THE INITIATIVE

The goals of studying practice breakdown are to develop a consistent approach to assessing patient safety and reporting errors that will increase knowledge and incentives for error detection, reporting, and prevention while fulfilling the duty to protect the public from unsafe practices. These goals constitute a paradigm shift that reframes the focus from the individual, the nurse, to one that emphasizes prevention and the implications for the health care system, the health care team, and the individual nurse. The mechanism for achieving these goals was to create a standardized data collection instrument for investigators throughout the United States who carry responsibility for examining incidents of practice breakdown. The instrument, described below, is entitled Taxonomy of Error, Root Cause Analysis, and Practice Responsibility, or "TERCAP®." The PBAP also created additional products and initiatives that are discussed in this chapter.

FOCUS OF THE BOOK

This book presents an overview of the work that the NCSBN has undertaken to assist others committed to improving patient safety. The elements of this initiative include a framework for analyzing practice breakdown, the data collection instrument TERCAP, and selected tools and practices to implement its use.

This framework and ways of thinking about practice breakdown are useful not only for boards of nursing but also for nursing students, faculty, nurses in practice, hospital and other health care administrators, and other accrediting and regulatory agencies that oversee and support the practice of nursing. It is expected that this framework and way of thinking will also be useful to policy makers and those developing, refining, and reframing nurse practice acts. Finally, this work provides the evidence and creates an infrastructure for a major change in the way nurses conceptualize and manage practice breakdown.

PATIENT SAFETY: A DEFINITION

Cooper et al. (2000) describe patient safety as "... the avoidance, prevention, and improvement of adverse outcomes or injuries stemming from the processes of health care (errors, deviations, accidents) ..." (National Patient Safety Foundation, 1999, pp. 1-2) and suggest that improving safety depends on learning the ways in which safety emerges from interactions of the components. Woods calls for "... research that matters ... to identify critical success factors by moving beyond morbidity and mortality (dedicating a) larger role to functional status, caregiver burden, satisfaction with care, costs of care and cost-effectiveness" (Woods, 2004).

RATIONALE FOR THE INITIATIVE

Members of the NCSBN have expressed, for quite some time, concerns about the lack of evidence for the discipline and began to examine discipline practices from an anecdotal perspective in the 1990s. Concern persisted for the value of board sanctions such as probationary mandates, official censure, and nondisciplinary letters and their relationship to nurse behavior. Board members and staff are uncertain about whether the discipline imposed provided the intervention to effect improvement in practice behavior. The PBAP was formed in 1999 because of these concerns. Further, around this time, the Institute of Medicine (IOM) began publishing its work on patient safety.

INSTITUTE OF MEDICINE REPORT

There have always been medical and nursing errors, and these errors have always been of concern to both practitioners and patients. In 1998 the IOM captured the attention of both the media and the public when it published its landmark report *To Err Is Human* (Kohn et al., 2000) and identified the pervasive reality of errors related to health care. Since then, patient safety has become an overriding concern of the public at large, and some characterize this concern as a crisis of faith.

The IOM produced a second report in the fall of 2004 entitled *Keeping Patients Safe: Transforming the Work Environment of Nurses* (Page, 2004). Several aspects of the report include implications for research in practice breakdown. Of particular interest is Recommendation 7-2.

> The NCSBN, in consultation with patient safety experts and health care leaders, should undertake an initiative to design uniform processes across states to better distinguish human errors from willful negligence and intentional misconduct, along with guidelines for their application by state boards of nursing and other state regulatory bodies having authority over nursing (Page, 2004).

In the United States, the most appropriate place to examine this phenomenon would occur at the state level, through the state boards of nursing. This is because these boards are charged with the task of addressing key issues that are informed by the principles that guide their actions.

THE WORK OF BOARDS OF NURSING

The work of boards of nursing in the United States is complex for several reasons:

1. The primary obligation of boards of nursing is to protect the public through effective delineation of the scope of practice, licensure, certification, and discipline.
2. The public/patient should be protected from unsafe institutional design and policies that impede or prohibit safe, effective nursing care. Boards of nursing must distinguish between system, individual, and practice issues before determining the actual violation of a nurse practice act. For example, organizational system processes within health care settings often result in suboptimal or even forced choices between competing justified needs and demands of good patient care. Negative outcomes for some patients may come at the expense of meeting the crisis or emergency intervention requirements of other patients.
3. Evidence for effective professional accountability needs to be established. Effective decision-making results when the nurse recognizes the fiduciary/advocacy responsibility she/he has for the patient and is able to meet those responsibilities by adequate safe institutional design, orientation, and ongoing in-service education, staffing, and policies.

CUTBACKS, NURSING SHORTAGES, REDUCED HOSPITAL STAYS

Suboptimal institutional environments impede safe patient care. Many complex elements have contributed to this current crisis of faith in the health care system. Specifically, these elements in the form of errors came to the forefront as health care institutions implemented cutbacks in nurse-patient staffing ratios, increased nursing workload, overtime, and temporary employees. These cutbacks were exacerbated by the trend of shorter hospital stays for patients who were acutely ill and, in turn, some of the checks and balances that helped ensure patient safety were also eliminated. The nursing shortage further complicates the situation. This is partly because the complexity that results from reduced time for hospital stays and its concomitant compressed time allotment requires not only more nurses but nurses with higher levels of competence to assess, synthesize, and coordinate patient care needs.

CREATING A FAIR AND JUST HEALTH CARE CULTURE

Concerned health care organizations have recognized the complexity of these trends and their impact on practice breakdown. They worked to shift a health care culture that emphasized blaming the individual to one that looked to improve performance of the system and to reduce systems errors. Some experts have called for a no-blame culture as the solution to the problems resulting from fear and intimidation from error management. Much has been written about these no-blame cultures, viewed as a key mechanism to reduce errors and as an approach to what has evolved as a patient safety movement.

Most health care professionals recognize that shame, blame, and punishment for mistakes do not improve patient safety. In many situations, patient safety is compromised as situations are not fully analyzed and corrected for fear of further punishment. Many now recognize that a nonconstructive position is one in which an either-or position is taken—that is, where either the individual or the system is determined to be at fault, or where the system is always at fault and the individual is the victim. Rather, the desired expectation is a culture characterized by fairness and justice.

A *just culture* for practice breakdown management is one in which the reality of the environment, organizational cultures, and missteps are viewed as critical learning opportunities for patient safety, while also addressing carelessness, inattentiveness, and substandard practice as well as intentional misconduct in any work environment (Marx, 2001). The goal is to avoid the tendency to blame individuals for patient safety issues when the error is unintentional and is usually a product of many forces and mishaps that led to the practice breakdown. However, a just culture demands attention, repair, remediation, and discipline of those professionals who willfully ignore their professional standards. A just culture requires mutual support for a difficult and complex job, accountability for meeting the standards of good practice by all workers, and rigorous attempts to protect the public from unsafe practices. An additional goal is to avoid the tendency to blame individuals for patient safety issues when, in fact, more factors are involved than one person's actions alone. Shared practice responsibility is a critical consideration in addition to separate considerations of the individual and the health care system's contributions to practice breakdown.

An oppositional argument about *either an individual or a systems approach* is wrongheaded, since both are required in addition to carrying out the notions of good and upholding the standards of good practice of any person who is a licensed professional (Benner et al., 2002; Page, 2004). Such an oppositional view usually posits the individual as an isolated individual rather than a member-participant of a professional practice community that has publicly made a commitment to uphold the notions of good and standards of a particular profession. If the individual imagined is a competitive individual (as in an extremely competitive business model), then there can be no accounting for the moral sources and collective standards of practice, commitment to good practice, skilled know-how, ethos, and participation in the formative outcomes of an accredited professional educational program. Accrediting bodies such as the State Board of Registered Nurses accredit schools of nursing for imparting skilled know-how, knowledge of the discipline, and ethical comportment, which includes both self-improving practice and safe practice. Rather than thinking of the individual as self-maximizing or competitive, in a professional practice one needs to think of professionals (nurses, doctors, lawyers, clergy, etc.) as *members-participants* of the profession, committed to the notions of good internal to the practice (MacIntyre, 1984) and formed by their educational processes to have a fiduciary responsibility to their patients, clients, and parishioners.

Yet, Page (2004) and her colleagues point out:

> . . .An extreme systems perspective that recognizes no individual contributions to patient safety presents problems such as "learned helplessness" and failure to address instances of individual deficits in competencies or willful wrongdoing.