

# Guidelines for Reporting Practice Related Incidents to the District of Columbia Board of Nursing

## *A message from the Board of Nursing:*

*The Board is often asked by employers: **At what point it is appropriate to report a nurse to the Board for the purpose of possible disciplinary action?** These guidelines were developed to provide a mechanism for employers of nurses and the regulatory board to come together to promote a culture that promotes learning from practice errors while properly assigning accountability for behaviors, consistently evaluating events, and complying with mandatory reporting requirements. The framework the Board has chosen to use in making disciplinary decisions is "Just Culture". This document will provide you with an overview of the "Just Culture" principals and how the board will work with nurses and employers of nurses to implement these guidelines.*

# District of Columbia Board of Nursing

## Mission Statement

*"The mission of the Board of Nursing is to safeguard the public's health and well being by assuring safe quality care in the District of Columbia. This is achieved through the regulation of nursing practice and education programs; and by the licensure, registration and continuing education of nursing personnel."*

### Just Culture

David Marx, an engineer and attorney, who is well known for his work in patient safety and safe system design, describes "Just Culture" as follows:

***On one side of the coin, it is about creating a reporting environment where staff can raise their hand when they have seen a risk or made a mistake. On the other side of the coin, it is about having a well-established system of accountability. A "Just Culture" must recognize that while we as humans are fallible, we do have control of our behavioral choices.***

The principle behind a "Just Culture" is this: Discipline needs to be tied to the behavior of individuals and the potential risks their behavior presents more than the actual outcome of their actions. A "Just Culture":

- Places focus on evaluating the behavior, not the outcome;
- Requires leadership commitment and modeling;
- Distinguishes between normal error, unintentional risk-taking behavior and intentional risk-taking behaviors;
- Fosters a learning environment that encourages reporting of all mistakes, errors, adverse events, and system weaknesses (including self-reports);
- Lends itself to continuous improvement of work processes and systems to ensure the highest level of patient and staff safety;
- Encourages the use of non-disciplinary actions whenever appropriate (including coaching, counseling, training and education); and

- Holds individuals accountable for their own performance in accordance with their job responsibilities but does not expect individuals to assume accountability for system flaws over which they had no control.

“Just Culture” encourages discussion and reporting of errors and near misses without fear of retribution. It is a culture that focuses on the behavioral choices of the practitioner, not merely the fact that an error occurred or that a bad outcome resulted from an error.

- “Just Culture” recognizes that perfect performance is not something that can be sustained, and errors will occur. It recognizes that the threat of disciplinary action does NOT prevent individuals from making errors.
- In a “Just Culture”, there is agreement that even the most experienced and careful nurse can make a mistake that could lead to patient harm. There is recognition that nurses will make mistakes and that perfect performance is impossible.
- “Just Culture” is not a “blame-free” response to all errors. It focuses on the behavioral choice of the nurse, the degree of risk-taking, and whether the nurse deliberately disregarded a substantial risk. It holds the nurse accountable who makes unsafe or reckless choices that endanger patients.

### ***Guidelines for Reporting Practice Related Incidents to the District of Columbia Board of Nursing***

In fulfilling its mission to safeguard the public’s health and well being by assuring safe quality care, the Board is committed to nursing practice regulation that is prompt, fair, and appropriate to public protection. The Board believes protection of the public can be facilitated by fair and just treatment of nurses who are involved in practice events. The Board reacts promptly to complaints and allegations of violations of the Health Occupations Revision Act and Board of Nursing regulations. All allegations are evaluated with respect to the merits of the individual case and the potential harm to the public. The Board’s responses to substantiated violations fall within a continuum of remedial and disciplinary action.

The Board believes protection of the public is not enhanced by the reporting of every minor incident that may be a violation of HORA. This is particularly true when there are mechanisms in place in the nurse’s practice setting to identify nursing errors, detect patterns of practice, take corrective action, and monitor the effectiveness of remediation on deficits in a nurse’s behavior and practice including judgment, knowledge, training, or skill.

The purpose of this guide is to provide a mechanism for employers of nurses and the board to promote a culture that promotes learning from practice errors while properly assigning accountability for behaviors, and consistently evaluating events. As healthcare facility nursing leaders and DCBON staff

review and discuss events, these guidelines, will be utilized so that matters are handled as consistently as possible.

**The review of a practice issue by the employer may result in:**

1. **Consultation Only** - Employer supports nurse and no further action is needed.
2. **Employer Directed Corrective Action** - Employer addresses incident with nurse through system intervention, internal disciplinary processes, and/or individual remediation.
3. **Formal Reporting** – Employer submits report/complaint to Board. Board then conducts inquiry and/or investigation according to established policies and processes.

## **Guidelines for Reporting Practice Related Incidents to the District of Columbia Board of Nursing**

### **NON-REPORTABLE INCIDENTS**

**Definition:** Employee has failed to follow employment policies. They are generally not reportable as violations of HORA and therefore would not be addressed by the Board. There may, however, be circumstances that could merit the Board’s attention. Nothing in these guidelines is intended to prevent or discourage direct reporting of a potential violation to the Board of Nursing. Please contact the Board’s Practice Consultant with any questions about specific situations.

#### **Examples of Non-reportable Incidents:**

- No Call-No Show
- Failure to complete a 2 week notice (abrupt termination)
- Refusal to accept an assignment
- Rudeness or inappropriate verbal interactions with patients or staff
- “Nodding” or falling asleep momentarily, unless this is a pattern of practice, or results in patient neglect or harm
- Falsification of employment application (unless falsification relates to licensure status)
- Failure to follow agency policy (unless this is ALSO a violation of practice act)
- Failure to submit agency paperwork in timely manner (unless jeopardizes patient care versus reimbursement only)
- Mental/emotional problems or issues that do not impact or relate to the nurse’s practice

- Information related to mental or physical conditions of a nurse, when you are providing care for the nurse (which means information is protected)

## **Systems Issues**

**Definition:** Incidents that are primarily the result of factors beyond the nurse’s control

**Criteria:** Some incidents, whether minor or significant, may be the result of or influenced by systems factors, as well as by individual factors. Organizational and nursing leaders are responsible for evaluating and addressing system impact on any incident or event, regardless of reportability. Opportunities for system improvements may exist independent of, or in conjunction with, opportunities for individual improvement.

### **Examples of Systems Issues:**

- Malfunctioning equipment
- Staffing/work hour issues

## **Human Error**

**Definition:** Nurse inadvertently did something other than intended or other than what should have been done; a slip, a lapse, or an honest mistake.

### **Examples of Human Error:**

- One time medication error (wrong dose, wrong route, wrong patient, or wrong time)
- Failure to implement a treatment order due to oversight

<h2><b>Guidelines for Reporting Practice Related Incidents to the District of Columbia Board of Nursing</b></h2>
--

## **REPORTABLE INCIDENTS**

**Definition:** Employee demonstrates at-risk or reckless behaviors. At-risk behaviors may be reportable if it is determined that the nurse does not appreciate the risk and has a pattern of at-risk behavior. Reckless behavior is reportable as violations of HORA and therefore would be addressed by the Board.

## Examples of At-Risk, and Reckless Behaviors

### At Risk Behavior

**Definition:** Nurse makes a behavioral choice that increases risk where risk is not recognized or is mistakenly believed to be justified; nurse does not appreciate risk; unintentional risk taking. Generally the nurse's performance and conduct does not indicate that their continuing practice poses a risk of harm to clients or other persons.

#### Examples of At Risk Behavior:

- Exceeding scope of practice
- Pre-documentation
- Minor deviations from established procedure

### Reckless Behavior

**Definition:** Nurse makes the behavioral choice to consciously/willfully disregard a substantial and unjustifiable risk. Reckless nurse behaviors MUST be reported to the Board.

#### Examples of Reckless Behavior:

- Nurse leaves workplace before completing all assigned patient care (and does not report to another nurse) because he has a date waiting.
- Nurse observes patient starting to climb over bedrails but walks away without intervening.
- Nurse makes serious medication error, realizes it when patient experiences adverse reaction, tells no one, denies any knowledge of reason for change in patient condition, and falsifies documentation to conceal error.

*The District of Columbia Board of Nursing wishes to thank the North Carolina Board of Nursing for its graciousness in allowing the adaptation of its "Guidelines for Evaluating and Reporting Practice Violations to the Board".*