Strategy for Board Decisions & Remediation
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Via state’s police power
Duty to protect the public
  • By licensing
  • Stopping or limiting the practice of unsafe practitioners

To Err is Human (1999)
98,000 people die in hospitals from preventable medical errors/year
Many errors are either “system-related” or influenced by system and nurse
How do we analyze errors?

Person Approach
- focuses on the aberrant act

System Approach
- focuses on the cause, rather than the consequence

Just Culture

James Reason recommended that a just culture, one that draws a line between blameless and blameworthy actions, is an essential early step to creating a safe culture.

Steps in medication delivery to patient
Justice and Fairness

Disciplinary action

Learn from mistake

System Approach

System accountability

Just culture

Individual accountability

System Accountability

Council on Licensure, Enforcement and Regulation
Individual Accountability

- Reckless behavior
- Behavioral choices
- Human Error
- At-risk behavior

Regulatory Decision Pathway (RDP)

Goals
- Protect the public
- Incorporate just culture principles
- Increase consistency in discipline

Designed for
- Board of Nursing discipline decisions
- Cases of practice errors or unprofessional conduct

Focuses on
- Patient safety
- Whether system failure and/or behavioral choices by the nurse contributed to the error
- Remediation of nurses

RDP Strategy

System Evaluation
- Deficit in facility policies or procedure
- Responsibility of other providers
- Other contributing factors

Behavior Evaluation
- Concealment, falsification
- Unjustifiable risk
- Reasonably prudent nurse
- Mitigating factors
- History of errors
- Previous facility counseling
Evaluation of the RDP

Reviewed by 13 BONs, 183 cases

Majority of BONs thought the tool was:

- Clear
- Useful to BON discussions
- Effective in leading to consensus in BON decisions
- Led to conclusions the BON agreed with

Regulatory Decision Pathway

The Regulatory Decision Pathway (RDP) is designed for board of nursing (BON) discipline decisions in cases of practice errors or unprofessional conduct. With the use of the RDP, the BON’s discussion is focused on whether system failure and/or behavioral choices by the nurse contributed to the error. Through the use of the RDP, the BON will determine the type of behavior exhibited and whether disciplinary action or other action would assist in protecting the public.
Definitions

Mitigating Factors
- Extenuating, explanatory or justifying fact, situation or circumstance

Reasonably Prudent Nurse
- A nurse who uses good judgment in providing care according to accepted standards

Remediation
- Education or training to correct a knowledge or skill deficit

Substantial Risk
- A significant possibility that an adverse outcome may occur

System
- An organization's operational methods, processes or infrastructure/environment

Deliberate?

START

Were the actions of the nurse intended to deliberately harm the patient?

Bad Intent
- Deliberate act
- Possible intent to cause harm

RGN should notify the board/authorities regarding the deliberate actions of the nurse.

Deliberate?
Were there significant circumstances involving the system which contributed to the error?

NO

Did the nurse play a role in the error?

Communicate to the facility/employer regarding the significant system circumstances that contributed to the error.

Conceal/falsify?

Were there significant circumstances involving the system which contributed to the error?

Did the nurse play a role in the error?

NO

Did the nurse conceal the error or falsify the records?

Reckless

Nurse should collaborate with facility/employer to provide the BON with an action plan for system and nurse error.

Substantial risk? Mitigating factors?

Were there significant circumstances involving the system which contributed to the error?

Did the nurse conceal the error or falsify the records?

NO

Did the nurse disregard or consciously take a substantial risk?

YES

Were there significant mitigating factors that should be considered in the BON's decision?
### History of errors/remediation?

**Did the nurse disregard or consciously take a substantial risk?**

- **NO**

**Is there a history of other similar or serious errors by this nurse?**

- **YES**

**Did the nurse previously receive remediation or counseling for a similar error?**

- **YES**

- **NO**

**Were there significant mitigating factors that should be considered in the BON's decision?**

- **YES**

- **NO**

#### Mitigating Factors?

- Disciplinary action
- Supervision/monitoring
- Focused remediation

**At Risk**

- Supervision/monitoring
- Focused remediation
- Possible self-harm

**Human Error**

- Consider focused remediation
- Consider case management

### Reasonably prudent nurse?

**Is there a history of other similar or serious errors by this nurse?**

- **NO**

**Could a reasonable prudent nurse have done the same in similar circumstances?**

- **YES**

- **NO**

**At Risk**

- Supervision/monitoring
- Focused remediation
- Possible self-harm

**Human Error**

- Consider focused remediation
- Consider case management

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**CLEAR Annual Educational Conference**

**Regulatory Decision Pathway**

**New Orleans, Louisiana**

**Sept. 11-13, 2014**
Case study 1 - Avery

- Avery was administering I.V. fluids and medications and documenting their administration.
- Packed cells were ordered.
- Someone handed the first unit of packed cells to Avery and said, “Here’s the blood for your patient.”
- Avery administered the packed cells.
- That unit of blood was not intended for Avery’s patient.
Case review
Avery's history
- working at the hospital since graduation 2 years ago
- for the past 6 months, working in the ED
- no errors during her employment
- nursing license was unencumbered
- responsive during the BON disciplinary review process
- appreciated the risk of her actions

Following the RDP, what is your conclusion?

A. Bad Intent
   - Deliberately
   - Deserving of punishment
   - Admits to the violation

B. Reckless
   - Carelessness
   - Violation occurred
   - Nurse responsible

C. At Risk
   - Substandard
   - Premature
   - Fedex returned

D. Human Error
   - Contributed to the violation
   - Nurse responsible
   - Risk and error counseling

Following the RDP, what is your conclusion?

The Regulatory Decision Pathway RDP is a tool designed to help regulatory boards and agencies determine appropriate discipline for registered nurses involved in violations. It is based on evidence and considered in conjunction with other evidence and discipline guidelines. The RDP uses a systematic approach to evaluate factors related to the violation and other evidence and provides a structured framework for developing a recommendation for discipline.
Case study 2 - Sam

- Two units of packed cells were ordered
- Sam could not locate another staff member
- Sam performed a one person verification of transfusion record & bedside verification
- Began the transfusion
- Sam signed the transfusion record and left the cosigner signature area blank

Case review

Sam’s history
- Nurse of 15 years
- Working at this hospital for 1 year
- Reported several times for minor medication errors & once for not following proper procedure regarding documentation
- Nursing license was unencumbered

Following the RDP, what is your conclusion?

A. Bad Intent
   - Dishonesty
   - Intentional misuse
   - Intentional wrongdoing

B. Reckless
   - Disregard for life or health
   - Negligent or wanton
   - Intentional misconduct

C. At Risk
   - Supervision/monitoring
   - Supervision/communication
   - Supervision/organization

D. Human Error
   - Contribute to
canonical/clinical
   - Contribute to
canonical/education
   - Contribute to
canonical/medical

Note: should collaborate with another provider or nurse to ensure the learner is ready to implement the care plan for system and best care.
Never talked about patient outcome

The decision should be tailored to each nurse and the actual behavioral choices

Patient outcome

Model of Safety

- Consistent communication
- Nonpunitive error reporting
- Fairness