Department of Nursing
Policy #031

Reporting of Errors and Near Misses

Status:	Approved 7.13.2017 Revised 2.15.2019
Effective:	2.15.2019
Initiated by:	Admission, Progression, Retention and Graduation Committee
Relevant WAC, Standard or criterion:	WAC 246-840-513

Purpose

The purpose of this policy is to provide guidelines for maintaining a Just Culture. A Just Culture is a system used to implement organizational improvement by decreasing focus on errors, outcomes, and assigning blame, and at the same time increasing focus on reducing risk through system design and managing behavioral choices by individuals. When reporting errors and near-misses is encouraged, it is expected that students and faculty will be consistent and honest in their behavior, make the best choices, and learn from mistakes.

A Just Culture improves real accountability by holding students and faculty accountable for their performance. It does not hold students and faculty accountable for circumstances or system flaws that are beyond their control. A Just Culture supports critical analysis and constructive feedback, lends itself to continuous quality improvement in work processes, and gives nursing education systems that improve patient safety through feedback to facilities.

Heritage University Nursing is committed to the principles of Just Culture. Students and faculty are encouraged to report all safety issues in clinical facilities, whether real or perceived, to the appropriate person(s). Students and faculty who make errors, experience "near-misses," or witness other nurses or students make errors are strongly encouraged to report the incident with the purpose of fixing system problems and/or allowing others to learn from mistakes.

Policies and Procedure

Reporting and Documenting Errors and Near-Misses for Students
Student and faculty responsibilities after an incident vary slightly depending upon whether the incident was a near-miss or an error. See "Near Miss or Error Algorithm" below.

1. The primary responsibility of the student and instructor is to take care of the patient's immediate needs, and notify the patient's primary RN and health care provider.
2. After the patient's needs have been met, the student and Heritage University faculty will report the incident to the necessary individuals and complete the facility's required internal incident documentation.
3. The student will download the Root Cause Analysis (RCA) form from *MyHeritage* and complete the form to assist in determining the cause and contributing factors of the incident.
4. After completing the RCA, the student will make an appointment with his/her clinical faculty supervisor to review the incident.
5. After reviewing the RCA with the student, the clinical faculty supervisor will complete an Incident Evaluation Tool (IET) and select an action plan (console, counsel, remediate/Clinical Student Support Plan [CSSP], or sanction). The instructor will notify the student of the selected plan.
6. If an action plan involves student remediation or sanction, the student will meet with the clinical instructor and the Director of Nursing.
7. Completed RCA, IET, and CSSP forms will be kept in the student's academic file in the Nursing Department office.
8. All RCAs and IETs will be reviewed by the faculty APRG committee on a regular basis.

Reporting and Documenting Errors and Near-Misses for Faculty Members

1. The primary responsibility of the faculty member is to take care of the patient's immediate needs, and notify the patient's primary RN and health care provider.
2. After the patient's needs have been met, the faculty member will report the incident to the necessary individuals and complete the facility's required internal incident documentation.
3. The faculty member will download the Root Cause Analysis (RCA) form from *MyHeritage* and complete the form to assist in determining the cause and contributing factors of the incident.
4. After completing the RCA, the faculty member will make an appointment with the Director of Nursing to review the incident.
5. After reviewing the RCA with the faculty member, the Director of Nursing will complete an Incident Evaluation Tool (IET) and select an action plan (console, counsel, remediate, or sanction). The Director of Nursing will notify the faculty member of the selected plan.
6. If an action plan involves remediation or sanction, the faculty member will meet with the Director of the BSN program.
7. Completed RCA and IET forms will be kept in the faculty member's file in the Nursing Department office.

Reporting

1. Within two business days, the Director of Nursing shall report to the Nursing Care Quality Assurance Commission (NCQAC), on forms provided by the commission, events involving a student or faculty member that the program has reason to believe resulted in patient harm, an unreasonable risk of patient harm, or diversion of legend drugs or controlled substances.

Documentation

The Nursing Department will keep a log of all events reported by a patient, family member, student, faculty or health care provider resulting in patient harm, an unreasonable risk of patient harm, or allegations of diversion, and medication errors. The log will include:

- the date and nature of the event;
- the name of the student or faculty member involved;
- the name of the clinical faculty member responsible for the student's clinical experience;
- assessment of findings and suspected causes related to the incident or root cause analysis;
- nursing education program corrective action; and
- remediation plan, if applicable.

The Director of the BSN Program will log on to the NCQAC website and complete the required online reporting form.

The Nursing Department will use incident reporting logs to:

- prevent future occurrences,
- facilitate student learning, and
- use the results of incident assessments for on-going program improvement.

Definitions

Error - An act of omission or commission that contributes or could contribute to an unintended result

Near miss - An adverse event that was caught just before the treatment was given and could have been harmful or fatal

Normal Human Error - An inadvertent action caused by the failure of a system to facilitate people making good decisions, or a slip, lapse in judgment, or a simple act of omission

At-Risk Behavior Error - Errors made by people when the risk is not recognized; or the risk is believed to be minimal; or the risk is justified based on presenting circumstances

Reckless Behavior Error - Conscious disregard of substantial and unjustifiable risk

Root Cause Analysis - An assessment conducted to prevent recurrence of an event by identifying the reason(s) underlying an undesirable condition or problem in the system

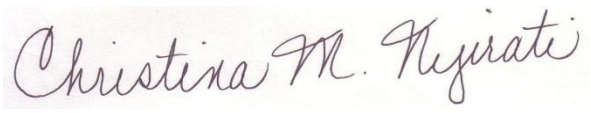
Forms

1. Decision Algorithm
2. Root Cause Analysis (RCA)
3. Incident Evaluation Tool (IET)
4. Clinical Student Support Plan (CSSP)

Reviewers

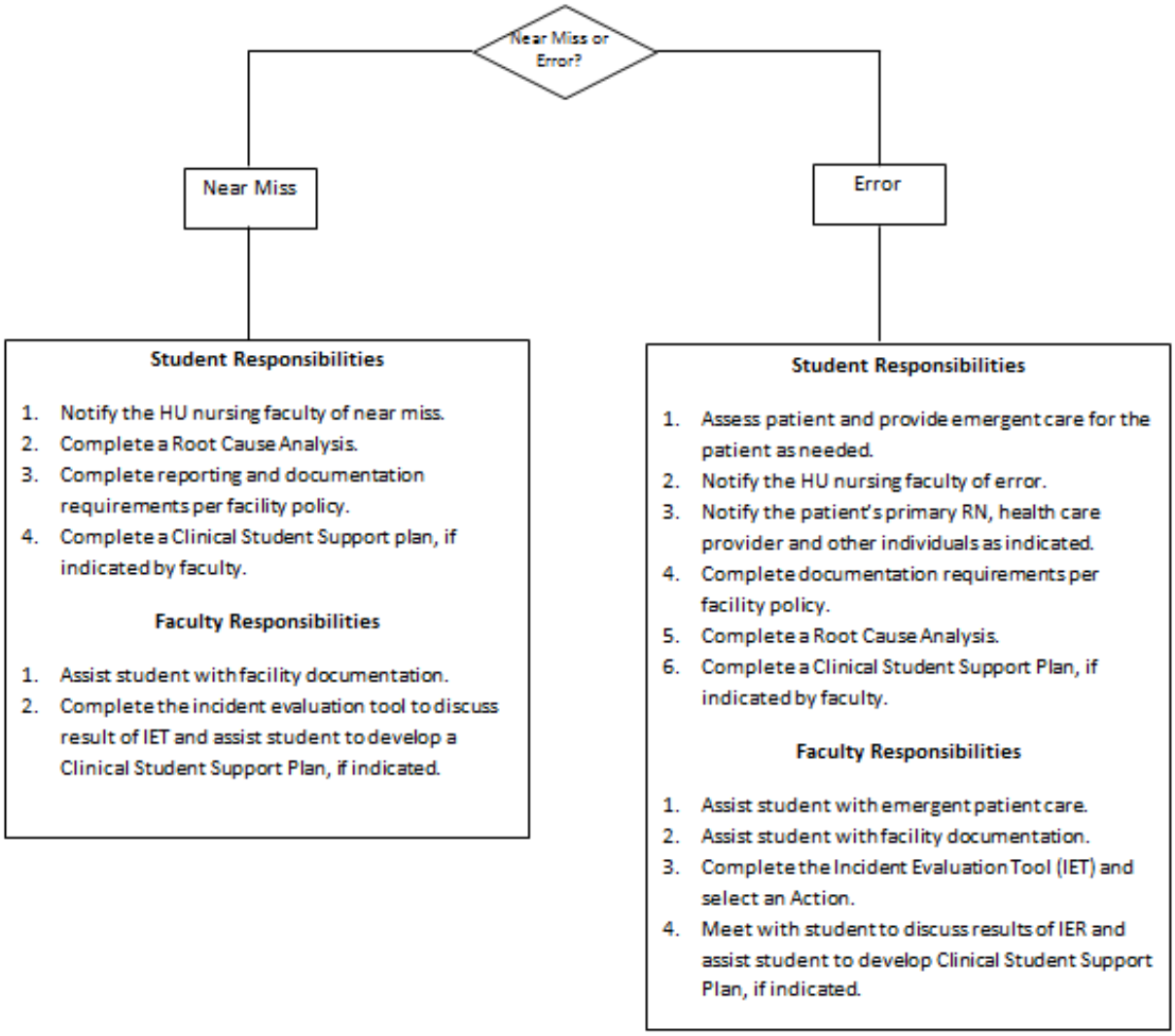
Proposed revisions of this policy should be reviewed by:

1. Director of Nursing
2. Admission, Progression, Retention and Graduation Committee
3. Nursing Faculty Assembly



Signature: _____

Decision Algorithm



ROOT CAUSE ANALYSIS
BSN PROGRAM

Root cause analysis is a method of investigation designed to identify the root causes – those factors that cause a chain of events that lead to an undesirable outcome. The form can be filled out electronically and saved. Please send a copy to your instructor when complete.

1. Information about the event.

Your Name	Click here to enter your name.
HU Nursing Instructor	Click here to enter your instructor's name.
Date of Report	Click here to enter today's date.
Date of Incident	Click here to enter the date the incident occurred or was discovered.
Location of Incident	Click her to enter the physical location where the incident occurred. EX. "patient's room", "hallway"
Did the error or near miss involve a medication?	Yes ☐ No ☐
What are the names of other people who were involved in the incident?	Click here to enter name(s).
Who did you notify about the incident?	Click here to enter name(s).

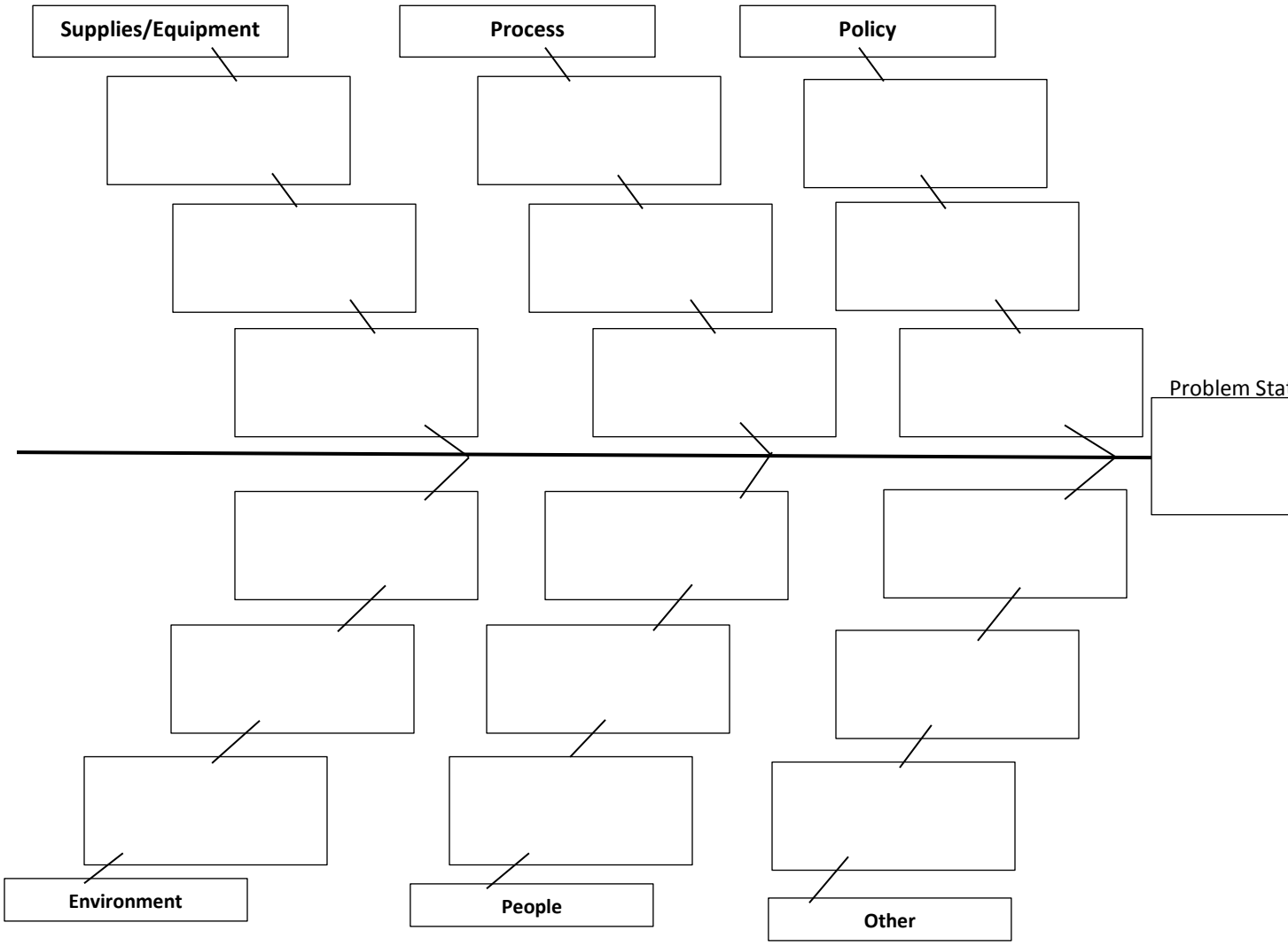
2. Description of the Error or Near Miss

Briefly describe the error or near miss that occurred. Be detailed and keep to the facts. Include dates and time if known. If the incident was related to a medication, list the name of the medication, and the dose, time and route of administration.

Click here to enter your answer to the question above.

3. Contributing Factors (Cause and Effect)

In the Problem Statement box, briefly summarize the error or near-miss. In the other boxes, list the factors that you believe contributed to the error or near-miss in each of the categories (not all categories may be applicable). Click in the boxes to add text.



4. Possible System Improvements

In your opinion, are there system improvements that could be made that might help someone else avoid this error or near miss in the future?

Click here to enter your answer to the question above.

5. Change in Personal Practice

How will you change your practice to avoid this incident form occurring again in the future?

Click here to enter your answer to the question above.

I have completed the RCA to the best of my ability based on my recollection of the vent that occurred.

Student's Electronic Signature: Click here to enter your first and last name..

Date: Click here to enter a date.

☐ ***I understand that checking this box constitutes a legal signature of my name above.***

6. Faculty Comments

Click here to enter text.

I have reviewed the RCA with the student

Faculty Electronic Signature: Click here to enter your first and last name.

Date: Click here to enter a date.

☐ I understand that checking this box constitutes a legal signature of my name above.

Policy #: 031
Title: Reporting of Errors and Near Misses

INCIDENT EVALUATION TOOL Page 1

Instructor's Name: Click here to enter text. Student's Name: Click here to enter text. Date: Click here to enter text.

Section I: Determination of Behavior Type

	Normal Error (error was a product of system design or a lapse)	**At Risk Behavior** (error was due to unintentional risk-taking; risk was not recognized or was believed to be justified)		**Reckless Behavior** (error was due to intentional risk-taking; conscious disregard of risk)	**Score**
	1	**2**	**3**	**4**	
Previously Reported Incidents	No previously reported incidents with evidence of "at risk" or reckless behavior. ☐	1reported incident with evidence of "at risk" behavior. ☐	2 reported incidents with evidence of "at risk "behavior, but incidents are dissimilar. ☐	2 or more reported incidents of a similar nature with evidence of "at risk" behavior. ☐	Enter Score
Practice / Level of Nursing Education	Practiced to level of education. Did not act beyond scope of knowledge or skills. ☐ O	Practiced beyond level of education due to pressure from qualified preceptor. Was directly supervised by qualified preceptor during incident. ☐	Practiced beyond level of education without direct supervision of qualified preceptor. Was unaware of level of education boundaries. ☐	Intentionally practiced beyond level of education without regard to patient safety or liability. ☐	Enter Score
Deviation from Standard, Policy or Physician Order (PO)	No standard, policy or PO was available to follow in the presenting circumstance. Breach was unintentional. ☐ O	Policy, standard or PO not enforced as evidenced by cultural norm (ie, staff commonly deviates from standard) or order was misinterpreted. ☐	Policy, standard, or PO clear but student deviated for a reason that appears plausible for the circumstances. Failed to utilize available resources to clarify. ☐	Intentionally `standard, policy, or PO. ☐	Enter Score
Decision/Choice	I ncident was inadvertent or accidental. ☐ O	Incident occurred due to rapid response required to avoid risk to patient. ☐	Incident occurred in non- emergent circumstances. Perceived that the advantage to act/ not act outweighed the risk to the patient. ☐	A prudent nurse would not have chosen to act / not act in the same situation. Put interests of self above that of patient. Intentionally ignored risk to patient. ☐	Enter Score
Accountability	Identified incident and self-reported. Displays honesty and remorse. ☐ O	Admitted to incident readily. Accepted responsibility when questioned. ☐	Admitted incident reluctantly. Attributed incident to circumstances to justify action/inaction. Cooperative. ☐	Denies responsibility for incident or actively attempted to conceal incident. Uncooperative or dishonest during investigation. ☐	Enter Score
				Total Score	Enter Total Score

INCIDENT EVLAUTION TOOL- BSN PROGRAM Page 2

Section II Mitigating and Aggravating Factors

Mitigating Factors (check all that apply)
☐ Breakdown in communication
☐ Recourses, supplies or equipment were unavailable
☐ Policy/procedure unclear/missing
☐ Contributing patient factors
☐ Lack of orientation, education, or training
☐ Other mitigating factors: Add explanation here.

Aggravating Factors (check all that apply)
☐ Patient identified as vulnerable
☐ Action or behavior of student was cruel or violent
☐ Create risk for more than one patient or healthcare provider
☐ Other aggravating factor: Add explanation here.

Criteria Score from Page 1: Enter score here. **# of Mitigating Factors:** Enter # here. **# of Aggravating Factors:** Enter # here.

Section III: Action Plan

Criteria Score 5-7 ***OR*** 3 or more Mitigating Factors ***AND*** no Aggravating Factors Action Console ☐	**No blame assigned. Console student. Discuss how the action or omission led to the error and how to prevent occurrence in the future. Identify systems that need improvement.** Add further action items here.
Criteria Score 8-10 ***AND*** 2 or more Mitigating Factors ***AND*** no Aggravating Factors Action: Counsel ☐	Counsel student on understanding "at-risk" behavior. Student may require increased supervision during high-risk activities for period of time. Add further action items here.
Criteria Score 11-15 ***AND*** no Mitigating Factors ***AND*** no Aggravating Factors Action Remediation & CSSP ☐	Student must complete a Clinical Student Support Plan (CSSP) the area of concern. Add further action items here.
Criteria Score 16-20 OR 1 ***OR*** more Aggravating Factors Action: Sanction ☐	Student may be dismissed from program. Refer to the Director of Nursing Add further action items here.

Faculty Electronic Signature: Click here to enter your first and last name.

Date: Click here to enter a date.

☐ I understand that checking this box constitutes a legal signature of name above.

I have read and understand the Incident Evaluation. I have had the opportunity to ask questions. My signature does not imply agreement.

Student Signature

Date

Comments:

CLINICAL STUDENT SUPPORT PLAN
BSN PROGRAM

Student's Name: Click here to enter name. **Today's Date:** Click here to enter a date.

Instructor:
Briefly describe the areas that you have identified as needing improvement.
Click here to enter text.

Student:
You have been asked by your clinical instructor to develop a plan for improvement. Please describe what methods or means you will use in the space below. Be specific and realistic. We have listed some ideas for success in the table below.

Click here to enter text.

Ideas for Success!

- ☐ Attend open lab to work on skills.
- ☐ Practice! Practice! Practice
- ☐ Enlist a classmate to help you with skills.
- ☐ Follow your textbook while practicing skills to make sure you aren't missing vital steps.
- ☐ Watch your classmates practice their skills and provide constructive feedback.
- ☐ Teach someone else the skills.
- ☐ Review Essential Skills modules
- ☐ Search YouTube for skills videos (be mindful of quality though)

We are here to help you! Please don't hesitate to ask the nursing faculty for assistance!

After completing your Clinical Student Support Plan (CSSP), please print it, sign below, and make an appointment with your instructor to review it. The CSSP will be kept in your file in the Nursing Department Office.

Student's Electronic Signature: **Date:**
Click here to enter your first and last name. Click here to enter a date.

☐ *I understand that checking this box constitutes a legal signature of my name above.*

Faculty's Electronic Signature: **Date:**
Click here to enter your first and last name. Click here to enter a date.

☐ *I understand that checking this box constitutes a legal signature of my name above.*