Nursing Practice Breakdowns: Breaking Down the Gaps Toward Building a Just Culture

Serena Bumpus, DNP, RN, NEA-BC

Background

1999

- 120,000 deaths and one million injuries caused due to medical error
- IOM report – To Err is Human

2018

- Medical errors 3rd leading cause of death
- 250,000 deaths per year

Because the greatest number of practitioners derive from the nursing profession, being sure the practice in that profession meets high standards and organizations have a structure in place to address systems issues, could facilitate a decrease in the number of people harmed each year due to medical errors

Problem

1987 - Texas is first state to pass nursing peer review (NPR) and minor incident rule

Texas is only state with both peer review and minor incident rule requirements

Board of Nursing: no authority to regulate how peer review operationalized

Purpose

Determine if Texas Minor Incident Rule and Nursing Peer Review requirements contribute to a just approach to addressing nursing practice breakdowns

Determine level of understanding nurse leaders in the State of Texas have of the minor incident rule and nursing peer review requirements.

Conceptual Framework

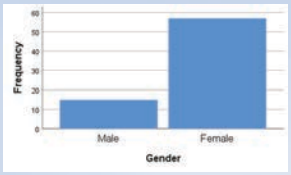
The Donabedian Model (Donabedian & Attwood, 1963) was used to assess and evaluate the effectiveness of current legislation relative to the structure, process, and outcomes of a just culture approach to practice breakdowns.

Methods

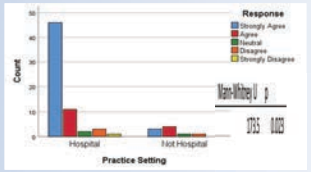
Created specific survey tool
Pilot tested to determine face validity
Distributed to Texas Organization of Nurse Executives

Results

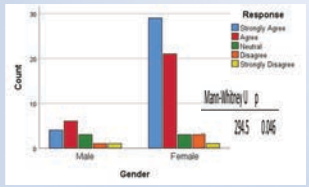
18 Demographic questions **26 Content questions** **72 Complete responses** **6 Statistically significant findings**

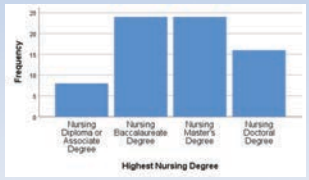


"I believe I understand the differences between Incident Based Nursing Peer Review and Safe Harbor Nursing Peer Review." by Practice Setting

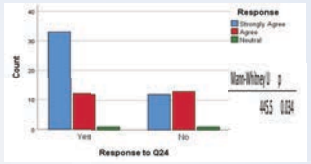


Belief of Understanding the New Minor Incident Rule Reporting Requirements by Gender

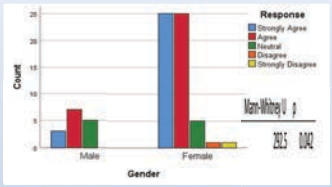


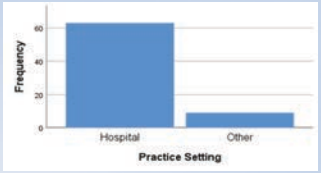


Experience with Minor Incident or Practice Breakdown and Agreement to Understanding Definitions of Each



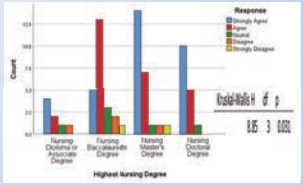
Belief of Organizations' Consideration of Nurses Knowledge, Judgment, Skill, Professional Responsibility, and Patient Advocacy Efforts by Gender





Experience with Minor Incident or Practice Breakdown and Agreement to Understanding New Reporting Requirements

Understanding of New Minor Incident Reporting Requirements by Education Level



Implications for Practice

Future studies needed:

Long Term Care
Rural Healthcare facilities
Ambulatory Care Settings
Community Health Settings
Free Standing Eds
Schools of Nursing
Large Healthcare Organizations

Limitations

Process is complex to understand
No enforcement accountability
Small response rate
Can only replicate in Texas

Literature Synthesis

- Chief nursing leaders have responsibility for all nurses and their practice.
- Nurse leaders are obligated to understand the complexities of regulatory requirements, particularly in tracking and reporting minor incidents and nursing practice breakdowns.
- Just culture aim to increase the accountability of appropriate reporting of nursing practice breakdowns as well as to provide clarity around the differences between human error, at-risk behavior, and reckless behavior (North Carolina BON, 2017; Marx, 2007).
- Texas minor incident rule and Nursing Peer Review requirement intent is to support a just culture in healthcare organizations.

Conclusion

Head in the sand mentality We still have work to do

- Identifying how healthcare organizations in Texas adhere to the minor incident rule and NPRC requirements is an important topic to understand in order to elevate the profession of nursing in Texas and support a just culture across all entities.
- Doing so will lead us toward stronger support for nurses and safer healthcare for patients.

References

Donabedian, A., & Attwood, J. C. (1963). An evaluation of administrative controls in medical care programs. *New England Journal of Medicine*

Marx, D. (2007). *Patient safety and the "Just Culture"*. Retrieved from http://www.wapatientsafety.org/downloads/0610-D-Marx.pdf

Meyer, M. (2010). *Nursing Law and Order*. Retrieved from Why don't all states have peer review for nurses?: http://advocatefornurses.typepad.com/my2cents/2010/09/why-dont-all-states-have-peer-review-for-nurses-like-the-great-state-of-texas.html, *269*(7), 347-354.

North Carolina State Board of Nursing. (2012). *Just culture in nursing regulation*. Retrieved from North Carolina State Board of Nursing: https://www.ncbon.com/vdownloads/cet/cet-booklet.pdf

Texas Board of Nursing. (2013). *History - Texas board of nursing*. Retrieved from Texas Board of Nursing: https://www.bon.texas.gov/history.asp

Texas Board of Nursing. (2013). *Practice - Peer review: Incident-based or safe harbor*. Retrieved from Texas Board of Nursing: https://www.bon.texas.gov/practice_peer_review.asp