Creating a data repository for tracking nursing student errors and near-misses

Jane Barnsteiner, PhD, RN, FAAN
Joanne Disch, PhD, RN, FAAN

Team
Judith Warren, PhD, RN, FAAN, FACMI
Susan Connor, PhD, MSN, RN
Fabiana Brogren, BA
Amogha Gundavaram, BTEC
Apoorv Hombali, BTEC
Objectives

- Share results of a survey to identify policies and tools for reporting nursing student ENMs
- Describe the role of a National Data Repository in improving the quality and safety of nursing student practice
- Identify the issues involved in establishing a national data repository
HOSPITALS MAY BE HAZARDOUS TO YOUR HEALTH
Changing Culture of Healthcare and Pre-Licensure Education

Moving from a *culture of blame* - identifying the individual and providing discipline

- hiding errors and near-misses
- preventing improvement

- 37% nurses reported that they had not reported an error that might be personally or professionally damaging (Cohen, 2008)
- to a **just culture**

an atmosphere of trust in which people are encouraged, even rewarded, for providing essential safety-related information - but in which they are also clear about where the line must be drawn between acceptable and unacceptable behavior

- Creating an open, fair, and just culture
- Creating a learning culture
- Designing safe systems
- Managing behavioral choices

*Koren et al (2007): EPP vs EPE* error-prone person vs. error-prone environment
What do we know about schools of nursing?

- Often a culture of silence exists
  - If you’re a good faculty member, your students don’t make mistakes
  - If you talk about mistakes, you condone them
  - If you share information about student performance, you influence another faculty member’s perception of a student
- Many faculty are not familiar with safety science and human factors
Purposes of the Study (Nov 2011 – July 2013)

- collect and analyze information on current practices and policies for reporting and trending ENMs
- create an electronic reporting tool
- create a national data repository for tracking and trending ENMs by nursing students in pre-licensure programs

**Funding:** National Council of State Boards of Nursing
Phase I: Collect and analyze information on current practices & policies

- Web-based survey of U.S. pre-licensure nursing programs
  - Demographic information
  - Presence (and copy) of
    - a policy for reporting and follow up of student errors and near-misses
    - a tool for reporting student errors
Web-based survey sent to 1667 schools
- 557 (33%) responded
- 900 pre-licensure nursing programs
  (Some schools with > one type program)
Phase 1: Existence of SON tool and/or policy

- 86 (16%) had a tool and/or policy
  - 6 error/near-miss policy only
  - 7 reporting tool only
  - 73 both a policy and a tool
    - In 9 schools, the tool did not fit the policy
Names of tools/policies

- Incident report
- Clinical advisement notice
- Safety reporting tool – error report
- Event discovery report
- Violation of policy form
- Critical incident report
- Student occurrence report
- Variance report form
- Learner prescription for remediation
Phase 2: Develop Occurrence Reporting Tool

Pilot

• 10 Schools of Nursing participated in 3-month trial
• 70 error/near-miss reports submitted

www.GRaSSP.org

Generating reports about safe student practice
## Information About Incident

### Recipient of Unsafe Event
- **Who received injury?** Patient
- **Gender**
  - Male
  - Female
  - Not reported
- **English is predominant language**
  - Yes
  - No
  - Unknown
- **Status of patient/individual**
  - Harm
  - No harm
  - Death
  - Other
- **Age** 15-20

### Location of event
- Classroom

### Who is completing the report?
- Student
- Faculty
- Student/faculty dyad

### Follow-up Action
- **Who is alerted?**
  - Faculty
  - SON administration
  - Patient/family
  - Other
  - Unknown
- **Inform clinical agency**
  - Yes
  - No
  - Unknown
  - N/A
- **Agency incident report completed**
  - Yes
  - No
<table>
<thead>
<tr>
<th>Type of Incident</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication error</td>
</tr>
<tr>
<td>Needle stick</td>
</tr>
<tr>
<td>Inadequate preparation for providing patient care</td>
</tr>
<tr>
<td>Blood/pathogen exposure</td>
</tr>
<tr>
<td>Fall event</td>
</tr>
<tr>
<td>Outside scope of practice</td>
</tr>
<tr>
<td>Injury to body</td>
</tr>
<tr>
<td>Change in patient condition</td>
</tr>
<tr>
<td>Deviation in protocols</td>
</tr>
<tr>
<td>Equipment or medical device malfunction</td>
</tr>
<tr>
<td>Environmental safety – for self, patient, or others</td>
</tr>
<tr>
<td>Inappropriate or inadequate communication by: Faculty, preceptor, other student, other student, health care team, patient, or visitor</td>
</tr>
<tr>
<td>Breach of confidentiality</td>
</tr>
<tr>
<td>Other</td>
</tr>
</tbody>
</table>
Phase 3: Establish a national Data Repository

**GRaSSP** – *(Generating reports about safe student practice)*

- a national, Web-based data repository for the anonymous reporting of errors and near misses by nursing students, faculty members, or both
- SONs would become members of a GRaSSP Network
  - Data tracking and trending
  - Benchmarking
  - Identifying best practices
  - Bases for research and curricular revision
  - Provide data for accreditation and other reports
  - Promote a fair and just culture
- Could eventually be used by all health professions’ programs
Issues in setting up a National Data Repository

- Data security
- Data confidentiality
- Ownership
- Financial considerations
  - Setting up
  - Maintaining
The main challenge

How to assure confidentiality -
- Statutes vary state by state
- Our Plan: use “peer-review protected” process
  An educational institution such as the school of nursing does not qualify as a review organization.
  • The data repository could possibly be housed in a state-based organization but would that be consistent with its mission?
  • There were nursing organizations in the state that could possibly qualify but would the expense and complexity of a national database work?
What do we know?

- Few schools have a policy or a reporting tool re: ENMs
- Majority of schools with a policy do not reflect the philosophy of a Just Culture
- A majority of faculty do not understand components of a Just Culture
- Faculty are ready to take this next step
- An anonymous, electronic tool can serve as a standard reporting mechanism for reporting, tracking and trending ENMs
- A data repository would provide a very helpful resource to improve student/faculty understanding of ENMs and decrease their occurrence
References:

- Disch and Barnsteiner (2014). Developing a reporting and tracking tool for nursing student errors and near-misses. *JNR, 5*(1), 4-10.
Thank you – and questions?