Agenda

- Background

- Methodology

- Results

- Key Takeaways

Background

Patient Safety Culture and Barriers to Adverse Event Reporting: A National Survey of Nurse Executives

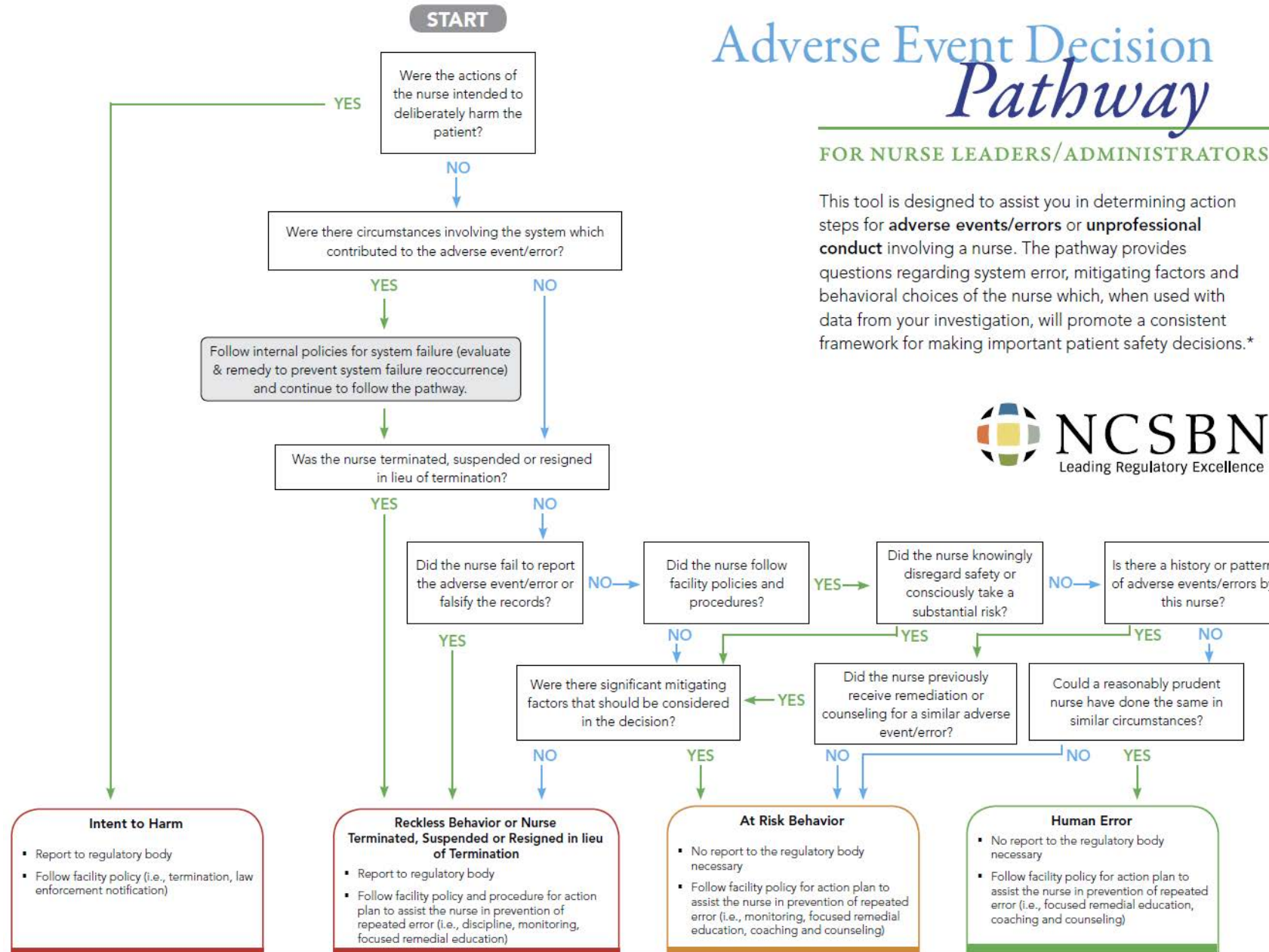Brendan Martin, PhD; Kyrani Reneau, MA; and Laura Jarosz

Introduction: Although boards of nursing (BONs) ensure nurse competency and fitness to practice through the regulatory process, it is nurse executives who enforce the Nurse Practice Act and standards of care in the clinical setting. As such, it is a nurse executive's responsibility to uphold the culture of safety. **Aims:** To better understand nursing executives' current protocols for reporting serious adverse events to state BONs and to identify potential reporting barriers. **Methods:** A national

Adverse Event Decision Pathway

FOR NURSE LEADERS/ADMINISTRATORS

This tool is designed to assist you in determining action steps for **adverse events/errors** or **unprofessional conduct** involving a nurse. The pathway provides questions regarding system error, mitigating factors and behavioral choices of the nurse which, when used with data from your investigation, will promote a consistent framework for making important patient safety decisions.*

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START

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

— YES → (to Intent to Harm)

— NO ↓

Were there circumstances involving the system which contributed to the adverse event/error?

— YES ↓ / NO ↓

Follow internal policies for system failure (evaluate & remedy to prevent system failure reoccurrence) and continue to follow the pathway.

Was the nurse terminated, suspended or resigned in lieu of termination?

— YES ↓ (to Reckless Behavior) / NO ↓

Did the nurse fail to report the adverse event/error or falsify the records?

— NO → Did the nurse follow facility policies and procedures?

— YES ↓ (to Reckless Behavior)

Did the nurse follow facility policies and procedures?

— YES → Did the nurse knowingly disregard safety or consciously take a substantial risk?

— NO ↓ Were there significant mitigating factors that should be considered in the decision?

Did the nurse knowingly disregard safety or consciously take a substantial risk?

— NO → Is there a history or pattern of adverse events/errors by this nurse?

— YES ↓ Did the nurse previously receive remediation or counseling for a similar adverse event/error?

Is there a history or pattern of adverse events/errors by this nurse?

— YES ↓ Did the nurse previously receive remediation or counseling for a similar adverse event/error?

— NO → Could a reasonably prudent nurse have done the same in similar circumstances?

Were there significant mitigating factors that should be considered in the decision?

— YES ← (from previous)
— NO ↓ (to At Risk Behavior) / YES ↓ (to Human Error)

Did the nurse previously receive remediation or counseling for a similar adverse event/error?

— NO ↓ (to At Risk Behavior)

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

— NO ↓ (to At Risk Behavior) / YES ↓ (to Human Error)

Intent to Harm
- Report to regulatory body
- Follow facility policy (i.e., termination, law enforcement notification)

Reckless Behavior or Nurse Terminated, Suspended or Resigned in lieu of Termination
- Report to regulatory body
- Follow facility policy and procedure for action plan to assist the nurse in prevention of repeated error (i.e., discipline, monitoring, focused remedial education)

At Risk Behavior
- No report to the regulatory body necessary
- Follow facility policy for action plan to assist the nurse in prevention of repeated error (i.e., monitoring, focused remedial education, coaching and counseling)

Human Error
- No report to the regulatory body necessary
- Follow facility policy for action plan to assist the nurse in prevention of repeated error (i.e., focused remedial education, coaching and counseling)

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*In addition to the considerations in the pathway, nurse leaders should be aware of (1) Laws and regulations requirements for special or mandatory reporting to the regulatory body and (2) provisions in the jurisdiction's law/regulations for reporting death or serious injury resulting from adverse event/error.

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Objectives

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Methodology

- **Design:** Cohort study

- **Sample:** Canadian nurse leaders

- **Data Collection:** Qualtrics

- **Analysis:** GEE models

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Demographics

- **Pre-Survey:** 21% (663/3,155)

- **Post-Survey:** 34% (125/369)

Table 1: Respondent & Facility Characteristics

Baseline Characteristics	Pre-Survey Total (N = 663)	Post-Survey Total (N = 125)
Professional Title		
Director of Nursing	155 (30.6%)	37 (30.8%)
Nurse Manager	112 (22.1%)	23 (19.2%)
Chief Nursing Executive/Officer	65 (12.8%)	18 (15.0%)
Other Director/Manager	61 (12.1%)	20 (16.6%)
Administrator	22 (4.4%)	5 (4.2%)
Patient Care Coordinator	12 (2.4%)	4 (3.3%)
Associate or Assistant Executive	17 (3.4%)	2 (1.7%)
Consultant	8 (1.6%)	2 (1.7%)
Other	54 (10.5%)	9 (7.5%)
Age (Mean, SD)	50.4 (9.4)	51.3 (9.2)
Sex		
Female	463 (91.9%)	116 (92.8%)
Male	41 (8.1%)	9 (7.2%)
Highest Education Degree		
Nursing Diploma	166 (33.0%)	43 (34.4%)
Baccalaureate degree	158 (31.4%)	37 (29.6%)
Master's Degree	170 (33.8%)	43 (34.4%)
PhD	9 (1.8%)	2 (1.6%)
Province		
Ontario	467 (70.4%)	99 (79.2%)
British Columbia	196 (29.6%)	26 (20.8%)
Health Care Facility Type		
Long-term care	174 (34.6%)	37 (30.6%)
Hospital	142 (28.3%)	35 (29.0%)
Community	77 (15.3%)	19 (15.7%)
Retirement Home	26 (5.2%)	6 (4.9%)
Private Healthcare Facility	12 (2.4%)	5 (4.1%)
Public Health	11 (2.2%)	5 (4.1%)
Other	60 (12.0%)	14 (11.6%)
Health Care Facility Setting		
Urban	288 (57.6%)	77 (62.6%)
Rural	129 (25.8%)	25 (20.3%)
Suburban	83 (16.6%)	21 (17.1%)
Facility Bed Size (Median, IQR)	140 (80 − 258)	150 (80 − 248)

Note: SD = standard deviation; IQR = interquartile range. Valid N for each item varies based on observed non-response rates.

Baseline Adverse Event Reporting

⭐ **Existing Policy, Criteria, Guidelines:** 337, 65.6%

    ↳ **Established Criteria:** 194, 57.6%

    ↳ **Facility Policy:** 138, 40.9%

    ↳ **Decision-Making Tool:** 74, 22.0%

Somewhat/Extremely Satisfied: 215, 63.7%

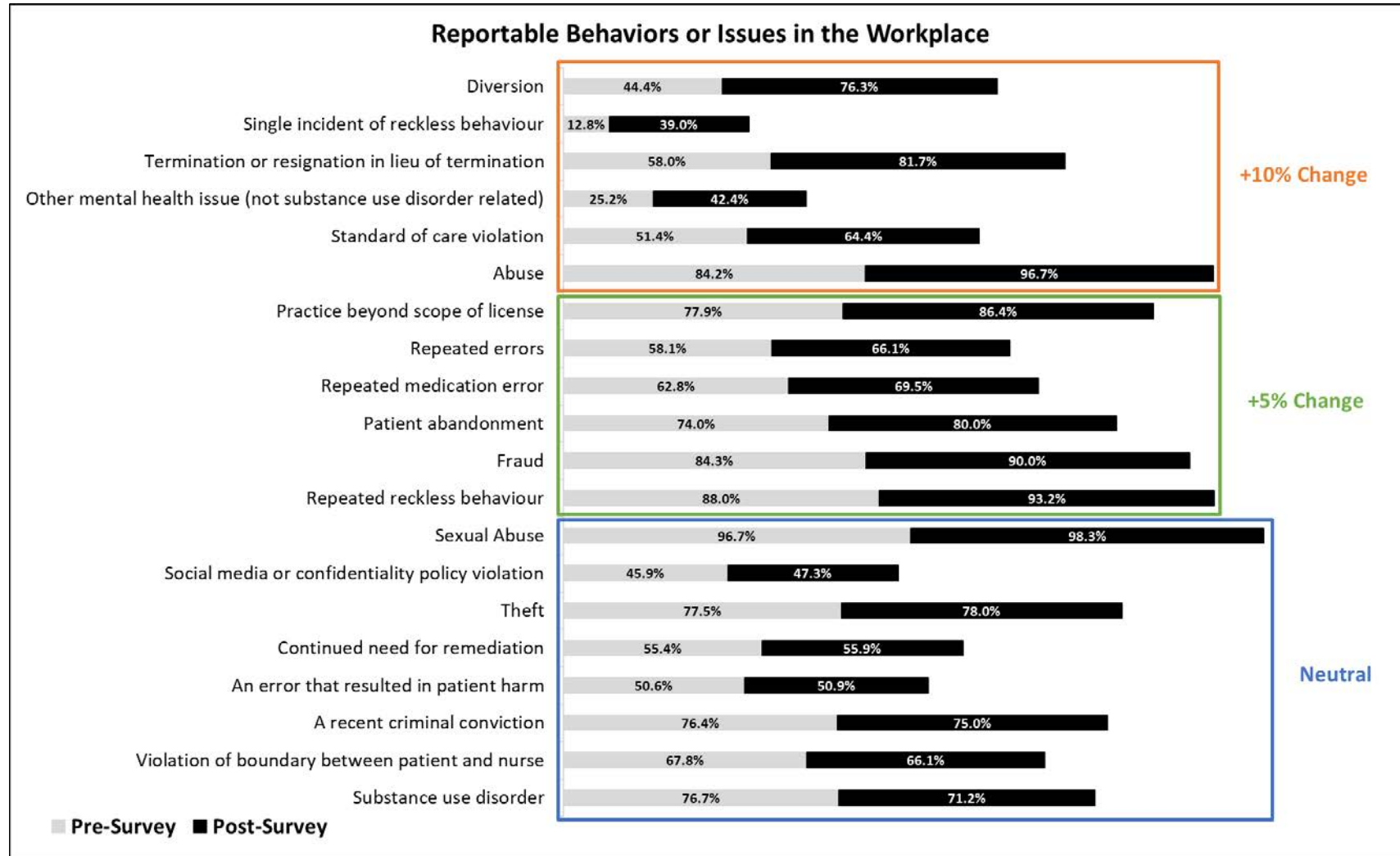| Title	n (%)
Director of Nursing	342, 63.8%
Nursing Manager	257, 47.9%
Chief Nursing Officer	342, 39.0%

None (**42.6%**)

Legal (**23.8%**)

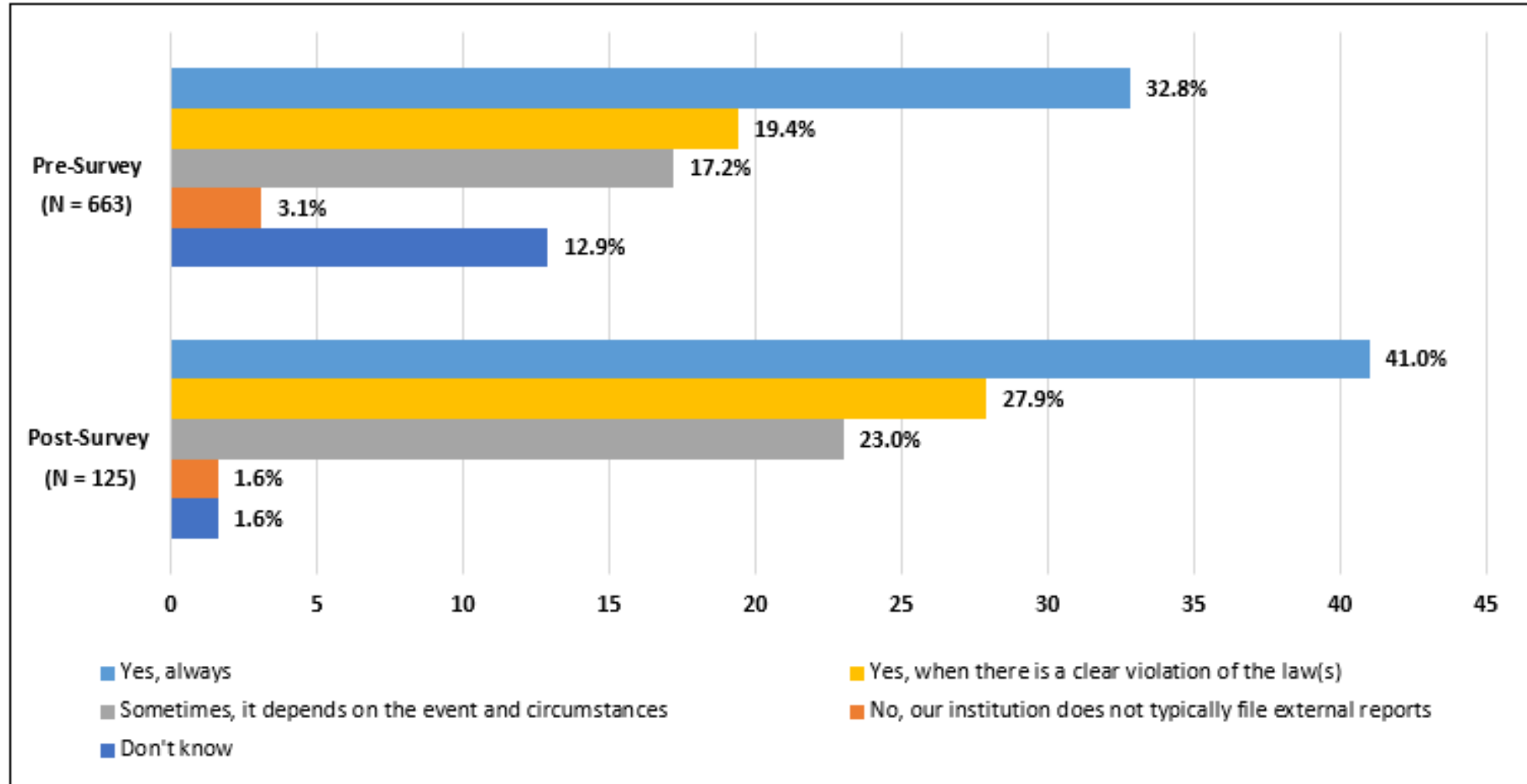What (**21.0%**)

How (**19.8%**)

Facility (**15.1%**)

Barriers to Reporting

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Adverse Event Reporting Using the AEDP

Reportable Behaviors or Issues in the Workplace

Adverse Event Reporting Using the AEDP

Key Takeaways

1) The AEDP tool is well-aligned with its target audience.

2) It does not increase adverse event reporting across the board.

3) The AEDP is an effective, evidence-based tool that can be used to support facility decision-making.

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Questions

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