

# Creating a Less Punitive Environment for Nurses



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Not only did the IOM's report *To Err is Human* (1999) deliver a wake-up call as to the prominence of errors in health care, it also challenged health care to rethink its perspective on errors. Conventional wisdom had suggested that errors were made by individuals, so if you found the person who made the error and corrected them, you fixed the problem. However, people don't usually make "mistakes" on purpose (then it isn't a mistake), so it is not a matter of education, of knowing better. It is a matter of being a fallible human being in a complex environment with many opportunities for error.

Some errors can be designed out of a process. For example, some things should never be connected to each other. Leaded gasoline doesn't belong in a no-lead tank, and because some individuals have made this error, the gas receptacle for no-lead tanks has been designed smaller than a leaded nozzle. The two don't fit, thus preventing one from filling up with the wrong kind of gas.

Unfortunately, we have not done as well in health care. Universal "luer locks" have simplified tubing connections to a fault – feeding tubes, epidural infusions, and blood pressure monitors can be connected to intravenous (IV) lines. Nurses are educated that feeding tubes should never be attached to IV lines, yet such errors have occurred with disastrous results. Experts in human factors engineering look

for ways to prevent human error by designing systems, such as different size gas nozzles, that interrupt the error. If feeding tube connectors were incompatible with IV lines, they could not be connected – the error would not occur. (There are ongoing efforts to eradicate universal connectors and thereby prevent tubing misconnections).

When the focus shifts from the individual who made the error (e.g., the nurse who administers a wrong medication) to factors contributing to the error (the medication was a look alike medication stored in Pyxis® bin adjacent to the ordered medication), fixing the problem goes beyond blaming the nurse for not following the seven rights of medication administration, to investigating how the hospital can ensure look alike medications are not stored in adjacent bins so another nurse does not grab the wrong drug. How the error occurred is more important that who made the error because knowing "how" enables a response that may prevent recurrence.

In addition, a focus on who made the error inhibits reporting of errors due to fear of repercussions either for oneself or one's colleague. Yet, the only way to prevent errors and design systems to prevent errors is to know about errors and near misses. A culture of safety depends on widespread reporting of errors and near misses so that systems and processes contributing to the error can be identified and corrected. We need the opportunity to learn from our mistakes.

The Texas Nurses Association has worked with the Texas Board of Nursing (BON) to promote movement toward a culture of safety and a shift from individual blame to problem solving and prevention. That is, when an adverse event occurs due to a nurse's error, the focus should be on identifying and fixing deficiencies in the system, not punishing the nurse. This legislative session, TNA initiated legislation to change the Nursing Practice Act to provide the BON with less punitive disciplinary options when a nurse commits minor violations. The BON's mission is:

*"...to protect and promote the welfare of the people of Texas by ensuring that each person holding a license as a nurse in the State of Texas is competent to practice safely."*

Additional options will enable the BON to focus its time and efforts on those nurses who truly pose a risk to public safety rather than those competent practitioners who have made errors within imperfect systems.

*Senate Bill 1415 and companion House Bill 1128* create the opportunity for the BON to take corrective action as an alternative to disciplinary action for minor violations. Because corrective action would not be considered discipline, it would not be public information and would not be displayed on the nurse's license. It is likely that the BON would utilize corrective action for nonpractice violations – those remedied by a fine or remediation. For

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secretary, A. Louise Dietrich, who would visit all nursing schools annually for the purpose of evaluation. With the legislation, nursing now had a legal means for uncovering inferior education in schools.

### Another 25 Years of Legislative Advocacy

If the first 25 years of professional nursing in Texas were bountiful in achievements, the last quarter of nursing's 100-year history is no less so. Legislative advocacy by Texas Nurses Association has consistently achieved elevated practice and education standards – year after year, legislative session after legislative session. From the early days of hospital nurse “training” when requirements were simple and included an age range of 19 to 35 years, good moral character, and success upon examination in reading, penmanship and simple arithmetic, nursing's come a long way. Through legislative advocacy, Texas nurses have:

### Workplace Safety and Safe Patient Handling

- First-in-the-nation Safe Patient Handling law that requires hospitals and nursing homes to adopt policies minimizing manual lifting.
- Required hospital policies that address violence and workplace safety for nurses.

### Advocacy and Whistle-blower Protections

- The right to request safe harbor peer review protection when refusing to engage in conduct believed to violate a nurse's duty to their patients.
- Whistle-blower protection when reporting concerns about patient care within a facility or to accrediting agencies; or when reporting other professionals for unsafe care.
- Protection from receiving a “bad employment reference” (“nurse does not follow

instructions”) when refusing to engage in conduct believed not in the best interest of patients.

### Legislative Investment in Nursing Education

- Nursing schools received more than \$55 million to increase enrollments and graduations to ensure nursing thrives as a profession.
- Research of nursing supply and demand through the Center for Nursing Workforce Studies.

**And...** nurse title protection, prescriptive authority and Medicaid reimbursement for advanced practice nurses, licensure mobility for nurses afforded through the Nurse Licensure Compact, and a peer assistance program for nurses experiencing chemical dependency and mental illness.

### The Year 2009

With the 81st Regular Texas Legislative Session having come to an end on June 1, nursing can add to its list of achievements for practice. With passage of SB 476, the Safe Hospital Staffing Act, nurses gained a greater voice in the decisions of nurse-to-patient staffing levels in hospitals. They gained an elevated role in assuring hospital accountability for safe and effective staffing through a now required direct involvement with hospital governing boards that must report nurse staffing information to the Texas Department of State Health Services. Through representation on a hospital Nurse Staffing Committees, nurses can help select the nurse-sensitive patient outcome measures that will be used to evaluate the effectiveness of the staffing plan. And, they can decline working mandatory overtime beyond a scheduled shift.

In this issue of *TEXAS NURSING Voice*, a continuing nursing education activity is offered on the Safe Hospital Staffing Act (see page 5). All readers can take advantage of the information on the new Texas law. Anyone wanting contact hours for the CNE activity can visit Texas Nurses Association online at [texasnurses.org](http://texasnurses.org). ★

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example, a nurse applying for Texas licensure forgets to acknowledge on her application that 28 years ago while in college she was arrested for participating in a public demonstration that became rowdy. When the BON completes the criminal background check, they note that the nurse's application omits this information – technically she has misrepresented herself to the BON and may be subject to disciplinary action. Yet, the nurse has had no practice or other legal issues in 28 years. Under this new statute, the BON could elect to take corrective action and issue a fine for not disclosing the previous legal history.

This legislation also enables the BON to conduct a pilot to evaluate the feasibility of using deferred disciplinary action as an alternative to disciplinary action for minor violations. Deferred disciplinary action would not apply to those cases in which the BON would propose to issue a reprimand, or to deny, suspend or revoke a license. For example, a nurse may be reported to the BON for making a fairly serious error. Upon investigation, the BON learns of significant system issues that contributed largely to the nurse's error. The BON believes the nurse is a competent and safe practitioner whose practice poses no public threat. A deferred disciplinary action option would allow the BON to impose conditions, such as remedial education or supervision as a condition of probation. During this period, the BON's action would not be confidential. Once the probationary period was completed, the BON could dismiss the complaint against the nurse and the deferred disciplinary action by the BON would become confidential and would not be displayed on the nurse's license.

The BON has a responsibility to ensure that nurses who practice are competent and safe. This legislation contributes to that effort by enabling the BON to consider alternatives to disciplinary action for minor violations without permanently affecting the nurse's license and by freeing up resources for the BON to focus on those infractions that may pose a true risk to patient safety. It represents one more step toward acknowledging the human nature of nurses and errors and assuring nurses that they will not be condemned for making a minor mistake.

Other Nursing Practice Act (NPA) changes include making confidential certain information (i.e. medical information) provided on licensure application and renewal forms and personal contact information provided for disaster relief programs. The NPA also now defines how the BON can utilize physical and psychological evaluations and the nurse's rights in the process.

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