

## Incident Reporting Policy

The School of Nursing (SoN) at Pacific Lutheran University complies with all Washington Administrative Codes (WAC) rules that relate to nursing education programs. Event reporting and recordkeeping requirements are in accordance with [WAC 246-840-513](#) that state, “The nursing education program shall keep a log of all events reported by a patient, family member, student, faculty or a health care provider resulting in patient harm, an unreasonable risk of patient harm, or allegations of diversion, and medication errors”.

The SoN is committed to fulfilling its role through reporting, investigation, analysis, plan for remediation and/or systematic corrective action of an event involving a student or faculty member that the program has reason to believe resulted in patient harm, an unreasonable risk of patient harm, diversion of legend drugs, or controlled substances, and medication errors. Systematic investigation and analysis of events qualifying for reporting and evaluation is essential to reduce risk and prevent patient harm, and protect public health and safety. This policy defines reportable events, and student, faculty, and administrator duty to report infractions based on the principles of just culture, fairness, and accountability in nursing education. Barnsteiner (2011) states that “organizations that have cultures of safety, foster a learning environment and evidence-based care, promote positive working environments for nurses, and are committed to improving the safety and quality of care are considered to be high reliability organizations (HRO).” PLU SoN seeks to become a contributing member towards achieving HRO status with our community clinical partners.

### Managing Healthcare Risk- The Three Behaviors

Normal Error	At-Risk Behavior (negligence)	Recklessness
What is it? “A product of our current system design”	What is it? “Unintentional risk-taking”	What is it? “Intentional risk-taking”
How can we manage this? <ul style="list-style-type: none"> <li>· Processes</li> <li>· Procedures</li> <li>· Training</li> <li>· Design</li> <li>· Environment</li> </ul>	How can we manage this? <ul style="list-style-type: none"> <li>· Understanding our at-risk behaviors</li> <li>· Remove incentives for at-risk behaviors</li> <li>· Creating incentives for healthy behavior</li> <li>· Increasing situational awareness</li> </ul>	How can manage this? <ul style="list-style-type: none"> <li>· Disciplinary action</li> </ul>

## **Just Culture**

According to the American Nurses Association (2010), principles of Just Culture were borrowed from the aviation industry and seek to “create an environment that encourages individuals to report mistakes so that the precursors to errors can be better understood in order to fix the system issues” (p.1). The SoN is committed to applying the principles of Just Culture to find a balance between blamelessness and corrective interventions for students and faculty practicing in nursing education settings. The SoN believes that applying principles of Just Culture to the educational milieu will:

- Promote a culture of safety
- Demonstrate the SoN’s commitment to patient safety initiatives
- Raise the level of transparency regarding clinical errors or near-misses
- Improve patient safety
- Understand how aggregate data from near-miss analyses are used to direct attention to critical safety issues for ongoing program improvement

## **Human Error**

Human error is defined as inadvertent action; inadvertently doing other than what should have been done; slip, lapse, mistake.

## **Near-miss**

Near-miss is defined as an unplanned event that did not result in injury, illness, or damage – but had the potential to do so. These events can represent an opportunity for students and faculty to identify and correct errors that have the potential to jeopardize patient safety.

## **At-risk Behavior**

At-risk behavior is defined as a behavioral choice that increases risk where risk is not recognized, or is mistakenly believed to be justified.

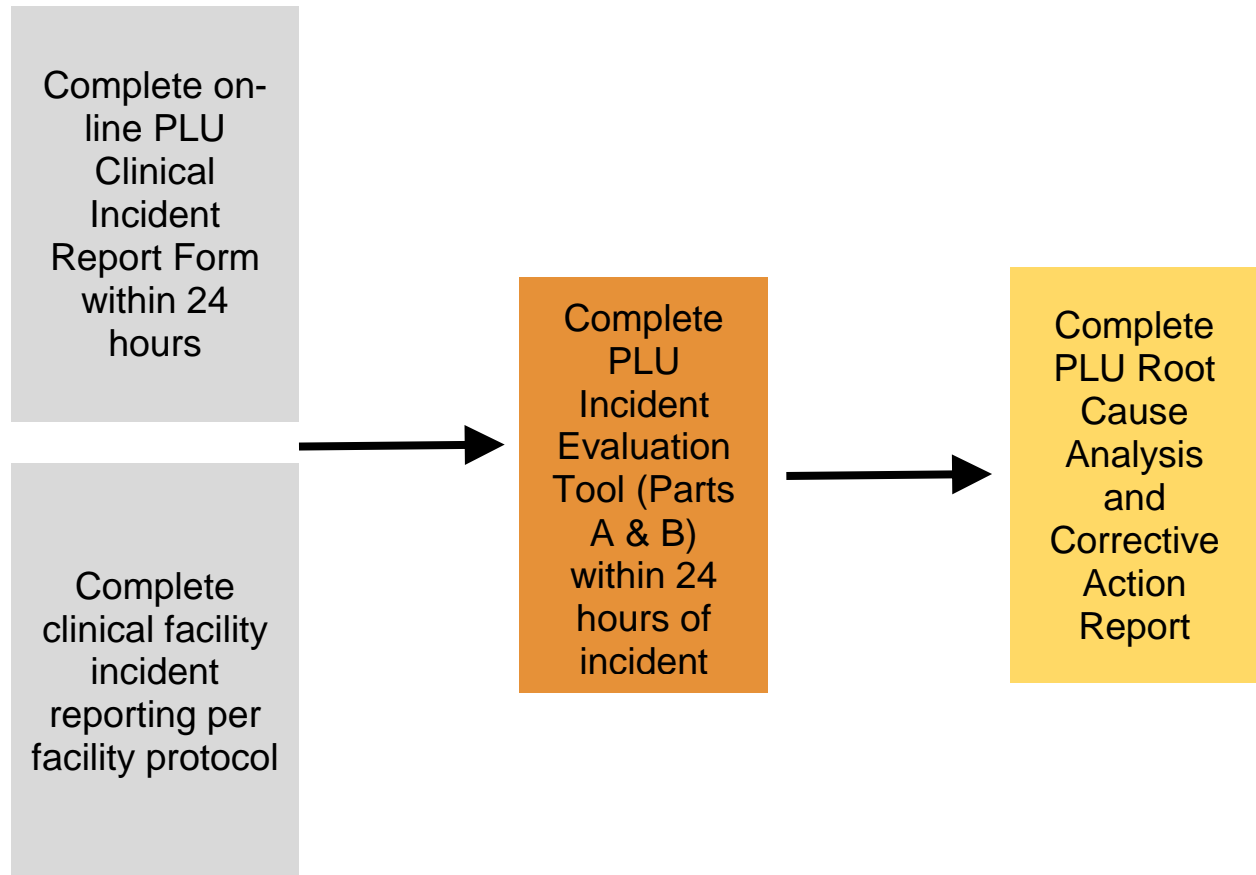
## **Reckless Behavior**

Reckless behavior is defined as a behavioral choice to consciously disregard a substantial and unjustifiable risk.

## **Clinical Facility Incident Reporting**

When an incident occurs, the student should notify faculty as soon as possible. Timely reporting of the incident is essential. Students, under clinical faculty supervision, will need to fill out the online School of Nursing Clinical Incident Report and possibly a University Injury Report. Incidences that occur within a clinical setting will simultaneously follow facility policy on incident reporting. Students should work with faculty to help determine the appropriate action for the specific type of incident.

Students and faculty that identify a clinical incident or near-miss will follow the following 3 step process:



The SoN Administration will review the documents to determine if consultation with Washington State Nursing Quality Assurance Commission (WA NQAC) is required based upon established criteria detailed in the Incident Evaluation Tool (part B). If the incident requires consultation or reporting to the WA NQAC, Chair of the Recruitment Admission Progression (RAP) Committee is responsible to assemble an ad hoc committee of members from the RAP committee, clinical faculty, course lead, and SoN administration to initiate a formal Root Cause Analysis and develop a plan for corrective action. SoN administration is responsible to keep a perpetual log of incidents and will investigate and report to the Chair of the Curriculum Committee, on a bi-annual basis, if incidents have occurred that require changes in the SoN curriculum.

## References

American Nurses Association. (2010). Just Culture. Retrieved from <http://nursingworld.org/psjustculture>.

Barnsteiner, J. (2011). Teaching the culture of safety. Online Journal of Issues in Nursing, 16(3). Retrieved from: <http://nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Vol-16-2011/No3-Sept-2011/Teaching-and-Safety.html>

Boysen, P. G. (2013). Just culture: A foundation for balanced accountability and patient safety. The Ochsner Journal, 13(3), 400-406. Retrieved from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3776518/pdf/i1524-5012-13-3-400.pdf>.

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