

# Employer Reporting of Nurse Practice Act Violations in California

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## Executive Summary

### Background

Chapter 520, Statutes of 2017 (SB 799, Hill) requires the California Research Bureau to prepare a report examining voluntary reporting of disciplined nurses by employers to the California Board of Registered Nursing (Nursing Board). As required by the statute, the report also must include a review of existing laws that require reporting in California and in other states, a list of laws “permitting, prohibiting, encouraging, or discouraging voluntary reporting” to the Nursing Board, a summary of employer reporting requirements in other boards within the Department of Consumer Affairs, under which the Nursing Board is housed, and options the state could consider for “consistent and reasonable reporting mechanisms.” This report contains the Research Bureau’s analysis of these issues. The report does not include a required analysis of employer reports to the Nursing Board. Though the Nursing Board maintains significant amounts of data, the relationship of the person reporting to the registered nurse who is the subject of the report is not currently collected. The Research Bureau found that this was also the case in three other states with which it collected detailed interviews.

### Reporting Practices

The primary purpose of professional licensing in healthcare centers on protecting the public from fraudulent and/or substandard care. Regulatory oversight can be broadly divided into two forms, prospective regulation that actively seeks out violations (e.g. police patrols), and reactive regulation that relies on reports of violations from the larger community (e.g. fire alarms). Among nursing boards in the United

States, including in California, the standard practice is to adopt a “fire alarm” approach toward the oversight of registered nurses. Aside from established requirements when renewing their license, once a registered nurse has received their license, they interact little with their state boards unless a complaint is made. Where states differ is in when, how, and who they require to submit a report of a violation.

Eighteen states (36 percent), including California, have no mandatory reporting rules for registered nurses. If someone believes a registered nurse has violated some portion of the Nurse Practice Act, that person has discretion about whether or not to report the alleged violation. Thirty-two states (64 percent) require mandatory reporting by one or more groups. This includes the nurse’s employer (19, or 38 percent), fellow nurses (27, or 54 percent) and/or other licensed medical professionals (8, or 16 percent). Taken together, the data shows no strong relationship between a state having or not having mandatory reporting rules, and the rate of complaints per licensee.

The non-mandatory approach adopted for registered nurses in California is fairly standard for other boards within the Department of Consumer Affairs, with only a few exceptions, including the Board of Chiropractic Examiners, the Respiratory Care Board and the Board of Vocational Nursing and Psychiatric Technicians.

### Barriers to Reporting

To begin an investigation, nursing boards must learn about alleged violations. For this to happen, employers, nurses and others must contend with multiple barriers. In a 2018 study,

37.2 percent of nurse executives stated experiencing some form of barrier that prevented them from reporting alleged violations, including uncertainty about what is reportable and having a non-punitive facility culture. Managers also have incentives to avoid strict reporting policies, including the impact that such reporting has on employee morale and turnover. Registered nurses can be reticent to report a colleague if they feel the error was unintended, or they could have easily made it themselves. In cases where a nurse has committed a medical error, the error can also have a systemic cause outside nurses’ control—such as inadequate staffing, frequent overtime, and intershift fatigue. Decentralized and fragmented medical healthcare delivery means cause of error can be spread over multiple practitioners, or due to poor communication and coordination. In such cases a licensee can be reticent to report a colleague if the error was not solely due to individual negligence or misconduct, but due to such systemic causes.

**Options for Reporting Mechanisms**

Given these barriers to reporting, there are several options the state can consider to

provide for more “consistent and reasonable reporting mechanisms.”

- Maintain current reporting practices:** Within the healthcare profession, there exists a norm of safeguarding patient health, and reporting dangers to patient safety. Furthermore, the data does not show a strong difference in the number of reports made among the 18 states with voluntary regimes, compared to the 19 states with mandatory employer reporting or the 13 states with some other form of mandatory licensee reporting. The only data that points to potential underreporting is in Connecticut, where the drug and mental health diversion program for healthcare professionals saw a 30 percent increase the year mandatory reporting was instated.
- Expand training and outreach efforts** (independently, or in conjunction with one of the other two options): One of the most significant barriers reported by nursing administrators was uncertainty about which behaviors constituted a reportable offense. This

Table 1: Count of States and Registered Nurses by Nurse Practice Act Violation Reporting Regime

	No Mandatory Reporting (i.e. Voluntary Reporting)	Mandatory Reporting by Healthcare Professionals		
		Mandatory Reporting for Employers	Mandatory Reporting for Registered Nurses	Mandatory Reporting for other Health Professionals
States	18	19	27	8
Licensees (RNs)	1,855,351	1,933,801	2,133,695	728,758
<p>Note: Some states have more than one mandatory reporting regime and can appear in multiple columns. Because comparable data was not available, the District of Columbia and Puerto Rico have been omitted from this review. Source: License counts are drawn from the National Nursing Database, 2017 Active RBN Licenses (<a href="https://www.ncsbn.org/6161.htm">https://www.ncsbn.org/6161.htm</a>).</p>				

indicates there is an opportunity to capture more unreported violations by increasing the level of outreach provided on the California Nursing Practice Act, with a particular focus on identifying violations and how to report them.

- **Enact mandatory reporting requirements:** These can vary by who is being required to report—employers, fellow registered nurses, or all licensed medical professionals more broadly—as well as in regard to the criteria used to trigger a mandatory report. The draft language included in early versions of SB 799 included one of the least restrictive approaches—only requiring employers to report dismissals, suspensions, or “resignations in lieu of dismissal.” Other states, such as Oregon, Florida and Connecticut, use a broader standard, including requiring employers to report to their nursing boards if a nurse is “unable to practice

his or her profession with reasonable skill or safety” under a variety of circumstances (Connecticut), if a “nurse's behavior or practice presents a potential for, or actual danger to, a client or to the public’s health, safety and welfare” (Oregon), or “any person who the licensee knows is in violation of this chapter” (Florida). Oregon is also implementing a Complaint Evaluation Tool, first created by the State of North Carolina, to assess and provide guidance and clarity about when and how to report a potential violation to the board. Oregon hopes that having a more objective criteria for reporting will both reduce the number of reports made to the board that are later found to lack merit, while also encouraging some valid complaints that might have historically gone unreported due to uncertainty about whether they should have initially been reported.

# Mandatory Employer Reporting Practices for Registered Nurses

## Introduction

The California Board of Registered Nursing (Nursing Board or Board), along with the Board of Vocational Nurses and Psychiatric Technicians (Vocational Nursing Board), is tasked with protecting the health and safety of Californians by licensing and regulating the practice of nursing in the state.

As part of a 2016 review of the Nursing Board, the California State Auditor assessed the Board's investigations and enforcement program. The audit noted a discrepancy between mandatory reporting requirements for licensed vocational nurses<sup>1</sup>—regulated by the Vocational Nursing Board—and registered nurses, regulated by the Nursing Board. Employers of vocational nurses are required to report to the Vocational Nursing Board when they suspend or dismiss a licensed vocational nurse, or if one resigns in lieu of dismissal. No such requirement exists for registered nurses in the state.

The audit recommended that the Legislature update the Nursing Practice Act to include a requirement that employers of registered nurses “report to BRN [Board of Registered Nursing] the suspension, termination, or resignation of any registered nurse due to alleged violations of the Nursing [Practice] Act” (California State Auditor, 2016). Earlier versions of the bill requiring this report, Senate Bill 799 (Hill, 2017), included language implementing

this recommendation, although the provisions were ultimately removed and replaced with a requirement for a report by the California Research Bureau. SB 799 required the Research Bureau to prepare a report “that evaluates to what extent employers voluntarily report disciplined nurses to the board and offers options for consistent and reasonable reporting mechanisms.” It also required the report to “include, but be limited to...:

- (a) A review of existing mandatory reporting requirements that alert the board to nurses who may have violated this chapter.
- (b) A review of existing laws permitting, prohibiting, encouraging, or discouraging voluntary reporting to the board.
- (c) An analysis of the number of employer reports to the board, the number of those reports investigated by the board, and the final action taken by the board for each report.
- (d) Employer reporting requirements of other boards within the department.
- (e) Nursing reporting requirements of other states.” (Cal. Bus. and Prof. Code § 2761.5, 2017).

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<sup>1</sup> Referred to as Licensed Practical Nurses in every state with the exception of California and Texas.

## Background

### Early Licensure

Nursing as a formal occupation developed out of the professionalization of traditional patient-centered care-taking roles. While the role of a doctor is to focus on and treat the disease, the role of the nurse is to support and care for the patient, so they can recover and heal (Nightingale, 1876; Shaw, 1993). Recognizing that “unprepared or incompetent practitioners” posed a risk to public health, states began to regulate medical professions—including nursing—in the early 20<sup>th</sup> century (Russell, 2017). North Carolina passed the first Nurse Practice Act in 1903 (Wyche, 1938; Smith, 2009), which created a State Board of Examiners of Nurses and instituted an exam and licensure for nurses wishing to use the title “registered nurse.” New Jersey, New York and Virginia followed with similar statutes later the same year. California passed a similar law on March 20, 1905.

North Carolina’s nursing law included provisions allowing the board “to revoke any license issued by them for gross incompetency, dishonesty, habitual intemperance, or any other act in the judgment of the board derogatory to the morals or standing of the profession of nursing”; however, the law did not formally address how to report such violations, including specifying whether any reports would be mandatory.

Early nursing laws had other limitations as well. They did not restrict the practice of nursing under a title other than registered nurse,<sup>2</sup> formally define nursing, nor describe a scope of practice. Within a few decades, the need for further regulation was recognized, and the first “modern” Nurse Practice Act with such

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<sup>2</sup> North Carolina amended its nursing law in 1917 to remove this loophole, specifying that “no one shall represent herself or himself, or in any way assume to practice as a trained, graduate, licensed or

provisions passed in New York State in 1938 (Smith, 2009; Russell, 2017). The primary provisions of California’s current nursing law were enacted soon after, in 1939. By the 1970s, all states had this form of a Nurse Practice Act. Unlike California, most states regulate registered nurses and practical/vocational nurses through a single Board of Nursing—California, Louisiana and West Virginia are the only states to split oversight between two separate boards.

### Current Reporting Practices

The primary purpose of professional licensing in healthcare is centered on protecting the public from fraudulent and/or substandard care. To achieve this, the traditional role of the nursing board is to: (1) evaluate and certify educational programs, (2) verify the skills, training and education of new licensees, and (3) to identify and discipline individuals whose professional practice is deficient (Cooke, 2006).

Regulatory oversight can be broadly divided into two forms, prospective regulation that actively seeks out violations (e.g. police patrols), and reactive regulation that relies on reports of violations from the larger community (e.g. fire alarms) (McCubbins & Schwartz, 1984). Based on the Research Bureau’s review of nursing boards across the United States, it appears that the standard practice is to adopt a proactive “police patrols” model for monitoring the quality of educational programs, but to adopt the “fire alarm” approach toward the oversight of practicing nurses. Aside from continuing education requirements, once a registered nurse has received their license, they interact little with their state boards outside of regular licensure renewal, unless a complaint is made.

registered nurse in North Carolina without obtaining a license through the Nurses' Examining Board” (Wyche, 1938).

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Where states differ is in when, how, and who they require to submit a report of a violation.

All states have mechanisms to receive and investigate reports of violations of their Nurse Practice Act (See Table 1, above). Eighteen states (36 percent), including California, have no mandatory reporting rules for registered nurses. If someone believes a registered nurse has violated some portion of the Nurse Practice Act, that person has discretion about whether or not to report the alleged violation. Thirty-two states (64 percent) require mandatory reporting by one or more groups. This includes the nurse’s employer (19, or 38 percent), fellow nurses (27, or 54 percent) and/or other licensed medical professionals (8, or 16 percent). Table A-1, in the appendix, provides a detailed list of the reporting practices for each state, along with the number of registered nurses licensed by their boards, as of December 31, 2017. Taken together, the data shows no strong relationship between a state having or not having mandatory reporting rules, and the rate of complaints per licensee. On balance, this appears to indicate that there is not a large pool of unreported violations to capture by stricter reporting rules. However, because the data is so limited, it is not possible to discount other explanations for the patterns or to draw any causal conclusions.

### California

There are no universal reporting requirements for the three groups in Table 1 (employers, registered nurses and other healthcare professionals). However, there are specific conditions under which other entities are required to report information to the Nursing Board. These broadly fall into three categories, which are also generally standard across other states and include criminal conviction, discipline by other licensing agencies, or for child and elder abuse. Other than these specific instances, there are no statutory or regulatory requirements for a person or organization to report an alleged Nursing Practice Act violation in California. Nor are employers required to report if they fire, discipline or otherwise restrict the practice privileges of a registered nurse.

Court clerks in California are required to report to the Board if a registered nurse has been found to have “committed a crime, or is liable for any death or personal injury resulting in a judgment for an amount in excess of thirty thousand dollars (\$30,000) caused by his or her negligence, error or omission in practice, or his or her rendering unauthorized professional services” (Cal. Bus. and Prof. Code § 803, 2012). Licensees are also required to self-report in a number of specific instances. They are required

to report any conviction, as well as any disciplinary action they are subject to from another licensing entity, including those in California, other states, or at the federal level (Cal. Code Regs. tit. 16, § 1441, 2018). Licensees are also mandated reporters for child, dependent adult or elder abuse (Cal. Penal Code § 11166, 2016; Cal. Welf and Inst. Code § 15630, 2013). A registered nurse must report any abusive conduct by another licensee.

Two other circumstances may result in a report of an alleged violation to the Board of Registered Nurses.

- State law requires healthcare facilities to report specific adverse events to the California Department of Public Health within five days of the event, or within 24 hours if “an ongoing urgent or emergent threat to the welfare, health, or safety of patients, personnel, or visitors” (Cal. Health and Safety Code. § 1279.1, 2007). The director of the department “may” then send any evidence of nursing care violations discovered during its investigations on to the Board of Registered Nursing, for additional investigation and discipline (Cal. Health and Safety Code. § 1280.20, 2014).
- In California, hospitals are required to report the loss of any controlled substances to the Board of Pharmacy within three days (Cal. Code Regs. tit. 16, § 1715.6, 2018). The Board of Pharmacy is also required to report to the Board of Nursing when it receives a complaint about dangerous dispensing practices of certified nurse-midwives or nurse practitioners (Cal. Bus. and Prof. Code § 4175, 2017). The Board of Registered Nurses licenses both nurse-midwives and nurse practitioners. Both have the authority to prescribe medication. The statute does not, however, cover the largest pool of licensees at the Board—registered nurses—

as they do not have the authority to prescribe medications.

## Practices of Other Professional Licensing Boards at the Department of Consumer Affairs

This non-mandatory approach in Table 1 is common for other boards within the Department of Consumer Affairs, with some exceptions:

- The California Board of Chiropractic Examiners requires licensees to report any violations by another licensee (Cal. Code Regs. tit. 16, § 314). Furthermore, unlicensed individuals cannot own a chiropractic practice in California. This means that all chiropractors in the state are either self-employed, or employed by another licensee. As a result, chiropractors who are not self-employed are subject to mandatory employer reporting (Cal. Code Regs. tit 16, § 312.1, 2018).
- Employers of respiratory care practitioners in the state are required by statute—rather than regulation—to report if they fire or suspend a licensee (Cal. Bus. and Prof. Code § 3758).
- The Board of Vocational Nursing and Psychiatric Technicians, which has oversight of licensed vocational nurses—the other large group of professional nurses in the state—defines the failure to report a violation of the Vocational Nursing Practice Act (Cal. Bus. and Prof. Code § 2840-2895.5, 2018) by any licensee as unprofessional conduct (Cal. Bus. and Prof. Code § 2878, 2004). Licensed vocational nurses can face discipline for unprofessional conduct, including having their license revoked. Furthermore, any employer of a licensed vocational nurse is also required to report “the suspension or termination for cause, or resignation for cause” of any licensed

vocational nurse they employ (Cal. Bus. and Prof. Code § 2878.1, 2012). Both reporting requirements were added to statute in 2003. However, employers are not required to report if they discipline in a more limited fashion—for example, if they restrict a licensed vocational nurse’s privileges, or if they impose additional education or training requirements on a vocational nurse.

### Non-Mandatory (Voluntary) Reporting by Employers

It is not possible with the existing data to measure how often employers report violations to the Board of Nursing. While the Board does collect copious amounts of information relevant to investigating alleged violations, the precise relationship between the complainant and the target of a report is often unknown. However, there is reason to believe that—even without mandatory reporting requirements—employers of registered nurses in the state often voluntarily report dangerous or impaired actions. When the California Hospital Association surveyed its members, the association determined that most California hospitals have established processes for handling the reporting of alleged violations resulting in a firing, resignation or suspension, if at varying levels of formality (California Hospital Association, 2018). In some cases, the employers have formally documented policies and procedures. In other cases, there are established practices they follow, based on how they have handled such issues before. Hospitals also vary in who is responsible for making the decision to report. Decisions to report are typically made either by the chief nursing officer, or through the human resources staff, although reporting decisions may also go through risk management.

### Reporting Practices in Three Comparison States

To provide an in-depth comparison to California’s Nursing Board, the Bureau conducted phone interviews with staff from the boards of three other states that have different reporting structures: Connecticut, Florida and Oregon.

#### *Connecticut*

Among states that have mandatory employer reporting provisions, most codify the requirement within their individual Nurse Practice Act and limit the requirement to the nurse’s employers. However, some take a broader approach, expanding the mandatory reporting requirement to cover most if not all healthcare professions licensed by the state. Connecticut is an example of this. Until 2015, Connecticut had no mandatory reporting, i.e. it was a voluntary reporting state. That year, the state changed its laws to require that any “health care professional” or “hospital” report (to the state board of nursing) if any other healthcare professional “is, or may be, unable to practice his or her profession with reasonable skill or safety” for any of the reasons quoted below:

*(A) Physical illness or loss of motor skill, including, but not limited to, deterioration through the aging process;*

*(B) emotional disorder or mental illness;*

*(C) abuse or excessive use of drugs, including alcohol, narcotics or chemicals;*

*(D) illegal, incompetent or negligent conduct in the practice of the profession of the health care professional;*

*(E) possession, use, prescription for use or distribution of controlled substances or legend drugs, except for therapeutic or other medically proper purposes;*

*(F) misrepresentation or concealment of a material fact in the obtaining or*

*reinstatement of a license to practice the profession of the health care professional; or*

*(G) violation of any provision of the chapter of the general statutes under which the health care professional is licensed or any regulation established under such chapter. (CGA § 19a-12e(3)(b), 2015)*

The law went into effect on October 1, 2015, potentially offering a window into the likely impacts of transitioning from a voluntary reporting regime to a comprehensive mandatory one. Unfortunately, the Connecticut Department of Health does not track when employers are the source of violations reports, making it impossible to directly measure the impact of the law on employer reporting. From 2015 to 2016, the first year of implementation and the last year for which any data is available, the health department reported that the overall increase in reports of nursing violations was not substantial. This is not the result anticipated when the change was being debated. The department raised concerns that it might be overwhelmed by new reports, and be “unable to investigate the number of complaints generated within current resources” (Connecticut Public Health Committee, 2015).

In fact, due to separate budgetary issues, the department reduced the staff assigned to investigations of complaints against licensees between 2015 and 2016. While board complaints for healthcare professionals do not appear to have significantly increased, Connecticut’s alternative to discipline program, the Health Assistance InterVention Education Network (HAVEN) did see an increase in program enrollment. HAVEN provides a mechanism for nurses to undergo treatment for drug or alcohol addiction or mental illness without going through the traditional board disciplinary process. Connecticut’s HAVEN program reported a 30 percent increase in

enrollment between 2015 and 2016, necessitating the hiring of four additional staff. This increased enrollment in the HAVEN program is the only data to suggest that there is a pool of unreported violations that mandatory reporting rules could capture.

### *Florida*

Florida has a broad statute with mandatory reporting for all healthcare practitioners licensed by the Florida Department of Health (Florida Statutes 456.072(1)(i), 2018):

*(i) Except as provided in s. 465.016, failing to report to the department any person who the licensee knows is in violation of this chapter, the chapter regulating the alleged violator, or the rules of the department or the board. However, a person who the licensee knows is unable to practice with reasonable skill and safety to patients by reason of illness or use of alcohol, drugs, narcotics, chemicals, or any other type of material, or as a result of a mental or physical condition, may be reported to a consultant operating an impaired practitioner program as described in s. 456.076 rather than to the department.*

Unlike Connecticut, Florida’s statute does not include a requirement for facilities to report—the state only has that requirement for licensed practitioners. Just as in California and Connecticut, Florida does not record the relationship between the individual making the report and the licensee. As a result, it is not possible to estimate probable impact of this policy difference on the reporting rate of hospitals or other employers. During interviews, staff indicated that Florida does not pro-actively monitor the mandatory reporting provisions, although it does enforce the statute when a failure to report is discovered as part of another investigation. The enforcement of the reporting rules is also contingent to a degree on the

severity of the initial violation, such as the presence or absence of patient harm (Florida Department of Health, 2018).

While the state does not have formal outreach or training on reporting rules for facility administrators, it does provide outreach and training as the opportunity arises. Furthermore, Florida has specific provisions requiring licensees to take two hours of training on laws and regulations as part of its biennial continuing education requirements (Florida Department of Health, 2018).

### *Oregon*

Licensees in Oregon are required to report any “licensed nurse whose nursing practice fails to meet accepted standards” as well as if they have “knowledge or concern that a nurse’s behavior or practice presents a potential for, or actual danger to, a client or to the public’s health, safety and welfare” (OAR. 851-045-0090, 2018). This effectively results in managers being subject to mandatory reporting, as the vast majority of practicing nurses in Oregon are under the supervision of another licensed nurse. Licensed healthcare facilities are required to report any “suspected violations” by licensees of the board of nursing, with the exception of nursing assistants (ORS 678.135, 2009). In fact, the majority of reports of alleged violations in Oregon come from nurse managers (Oregon Board of Nursing, 2018).

Oregon has recently adopted North Carolina’s Complaint Evaluation Tool (North Carolina Board of Nursing, 2018; Oregon Board of Nursing, n.d.). The goal in adopting the tool is to provide guidance and clarity about when and how to report a potential violation to the board. The hope is that having more objective criteria for reporting will reduce the number of reports made to the board found later to lack merit, and also encourage valid complaints that have historically been under-reported due to uncertainty about whether they rise to the level

of reportable violation. A copy of the Complaint Evaluation Tool is in the appendix.

Oregon’s nursing board also focuses on training and outreach, providing educational presentations on Oregon’s Nurse Practice Act including when and how to report alleged violations of the Act. Board staff regularly travel the state to provide training to nurses, nursing managers, and chief nursing officers. The board estimates this outreach has increased reports by about 20 percent (Oregon Board of Nursing, 2018).

## **Barriers to Reporting Alleged Violations**

### **Employer Barriers**

Facility administrators and other employers are in a position to know about the skill and competence of the licensees they employ. They are among the first to discover if a standard of care has been violated, or if a licensee suffers from an impairment—such as substance abuse or an untreated mental illness—with the potential to affect the quality of care. It is this privileged position that has led 19 states to add mandatory employer reporting as part of their regulatory toolkit. However, employers also face a number of barriers and disincentives to reporting (Hudspeth, 2008; Budden, 2011; Martin, Reneau, & Jarosz, 2018).

Table 2: Barriers to Board Reporting Encountered by Nurse Executives

Barriers Encountered	Number Reporting	Percent Reporting
None	277	62.8%
Uncertainty as to:		
What is reportable	83	18.8%
The reporting process	53	12.0%
The legal ramifications	55	12.5%
Non-punitive facility culture	136	30.8%
Other facility policy	128	29.0%
Concern for legal exposure	40	9.7%
Concern for facility reputation	17	3.9%

Source: Martin, Reaneau and Jarosz (2018).

When researchers surveyed nurse executives on their reporting practices, a large minority—37.2 percent—stated experiencing some form of barrier that prevented them from reporting alleged violations to state nursing boards. Nurse executives reported a number of reasons preventing them from reporting (see Table 2); however, when Martin, Reneau and Jaosz (2018) conducted a combined multivariate analysis that looked at all barriers simultaneously, the two with the strongest evidence of impact were uncertainty about what is reportable and having a non-punitive facility culture. Executives at the nursing boards in California, Florida and Oregon all noted the challenge of employers understanding what is reportable, and each focused training resources on the issue. Non-punitive facility culture directly relates to job satisfaction and retention of nursing staff.

<sup>3</sup> Unsurprisingly, job stress and perceived work demands have a negative effect on a nurse's reported job satisfaction (Ellenbecker & al, 2007). When nurses exiting the profession were interviewed about the reasons for their decision to change careers, they cited emotional exhaustion and problems with work design as key causes (Aiken L. H., et al., 2001). More broadly, nurses' perception of organizational climate were also correlated with turnover (Stone P. W., et al., 2007). Zhang, Punnet, Gore, et al (2014) identified four key features that reduced turnover: getting along with supervisors,

How organizations respond to medical errors influences perception of the work environment, and ultimately turnover. A strong error-management culture focuses on pro-actively detecting, analyzing and handling and/or resolving errors. Such organizations rely on open communication around those errors and reward nurses who participate in knowledge-sharing and other assistance (Guchait, Paşamehmetoğlu, & Madera, 2016). Whereas error-elimination cultures are typically more centralized and punitive, error-management cultures are more cooperative and believed to result in increased group cohesion, as well as reduced stress and nurse burnout. As a result, organizations with such cultures experience lower rates of nurse turnover (Bakker, Demerouti, & Verbeke, 2004).<sup>3</sup>

Another potential barrier to employer reporting is that, if possible, employers prefer to deal

getting along with co-workers, feeling respected, and being able to make decisions during the course of their work. Nurses who reported high scores in those four areas had a 77 percent reduction in their reported intention to leave nursing. This can include the perceived level of centralization in the organizational structure (less was reported as better, on average), the ability to have flexible hours, an emphasis on professional autonomy, and the presence of strong communication between management and staff (Aiken, Smith, & Lake, 1994;

internally with correctable errors and deficiencies among their nursing staff (Martin, Reneau, & Jarosz, 2018). Reporting alleged violations that they see are correctable might result in the loss of a valuable employee.<sup>4</sup> Recent trends in California expect the state to be able to meet the demand for registered nurses through at least 2035. However, even without a shortage of qualified nurses, turnover still represents an important cost to employers. Over a decade ago, Waldman, Kelly, Arora and Smith (2004) estimated a \$15,582 average cost to replace a nurse lost to retirement or turnover. Hospitals and other employers of registered nurses invest in preventing unnecessary turnover among their nursing staff.

### Licensee Barriers (Self-Reporting or Colleague Reporting)

A report to a state board of nursing carries with it the potential for serious disciplinary consequences to the licensee. These consequences create strong disincentives against individuals self-reporting (Wolf & Hughes, 2008; Leape L. L., 1994). In addition,

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Buchan, 1994). A large part of the work environment is made up of the relationships nurses have with each other, with supervisors, and with other parts of the medical care team—particularly the doctor-nurse relationship. If these relationships interact to make the nurse feel supported and empowered, that will have a significant impact on improved job satisfaction (Breau & Rheume, 2014). Recognizing the professional nature of nursing is consistently cited in the literature as reducing turnover. Moore (2001) found that a nurse's intention to quit could be mediated by a sense of professionalism. This reduced the impact of frustration at changing work conditions, perceptions of poor management, and reduced the impact of burnout. Spence Laschinger et al identified organizations with a high level of group cohesion and autonomy as having a high level of "structural empowerment," which was correlated with overall job satisfaction, and ultimately, lower turnover rates (Spence Laschinger, Finegan, Shamian, & Wilk, 2001; Manojlovich & Spence

nurses can be reticent to report a colleague if they feel the error was unintended or they could have easily made it themselves (Cooper, et al., 2016). In cases where a nurse has committed a medical error, the error can also have a systemic cause outside nurses' control—such as inadequate staffing, frequent overtime, and intershift fatigue (Famolaro, Yount, Hare, Thornton, & al, 2018). Decentralized and fragmented medical healthcare delivery means cause of error may spread over multiple practitioners, or due to poor communication and coordination. This presents another barrier to reporting—a licensee can be reticent to report a colleague if the error was not solely due to individual negligence or misconduct, but due to systemic causes.

When a complaint has been made against a nurse, the state's evaluates the nurse's actions to first verify that unsafe actions occurred, and if so, to what extent the violation threatened patient safety. In general, increased severity of unsafe actions results in the board imposing an increased severity of discipline. Such an approach works well when considering nursing

Laschinger, 2002). Even something as simple as a nurse's perception that they had a shared role in decision-making was correlated with job satisfaction.

<sup>4</sup> In California—as in most states—there are continuing concerns about maintaining a registered nurse workforce adequate to meet demand, although recent studies of the California registered nurse workforce leave some cause for optimism. Nursing school enrollments doubled between 2001 and 2010 (Waneka & Keane, 2012). Anecdotally, one explanation for this increase was that individuals who lost their jobs during the recession of 2007 chose to enter school programs instead of continuing to look for work. Additionally, the recession led practicing nurses to remain in the profession when they might have otherwise retired or changed careers (Spetz, 2017). As a result of recent trends in California, forecasters expect the state to be able to meet the demand for registered nurses through at least 2035.

as a highly professionalized practice, with a large degree of autonomy (Beardwood & French, 2004). In such cases, it is reasonable to assume that the nurse was uniquely at fault. However, nursing culture is shifting toward less individual autonomy, and a higher reliance on organizationally determined top-down rules. As this occurs, the importance placed on individual accountability can sometimes put board regulation in tension with the cooperative nature of nursing. It can also make it easy to overlook many of the systemic sources of error in healthcare. Recognizing this issue, nursing boards have begun adapting their processes to reflect the changing nature of the profession. An example of this is the Regulatory Decision Pathway, developed in 2012 by the National Council of State Boards of Nursing specifically to provide a tool for state nursing boards to use in making discipline decisions (Russell & Radtke, 2014). A key focus of the tool is determining to what extent the adverse event resulted from systemic failure vs. how individual nurse behavior contributed.

Emphasis on a systemic understanding of medical error is being driven—in part—by research into nursing and healthcare outcomes. Starting in the 1990s, research efforts have examined how treatment success is interdependent across the healthcare team, facility, and subject to influence by outside factors (IOM, 2000; IOM, 2001). Complicating the issue is the fact that there is not one single approach to measuring health outcomes (Doran, 2011). Many studies see adverse events as outcomes of interest (American Nurses Association, 2000; Aiken L. H., et al., 2001; Needleman, Buerhaus, Mattke, Stewart, & Zelevinsky, 2002). While others look at more qualitative outcomes like functional status and/or mental and social well-being (Lush, 2001; Ditmeyer, Koepsell, Branum, Davis, & Lush, 1998), or a mix of both (McGillis Hall, et al., 2003).

A commonly adopted model of error in nursing literature is Reason's model of accident causation (Boysen, 2013). The potential for mistakes—what Reason calls “latent failures”—exist because of organizational deficits or other systemic issues. These deficits lay dormant within the system, and are typically undiscovered. The conditions under which the error occur are either poorly understood, or when they are recognized, are dismissed as unlikely (i.e. “black swan” events). These latent errors are typically embedded in the system because of decisions made when the organization and its processes were designed, which can be far removed from day-to-day activities. To a certain extent, it is impossible to avoid the potential for all latent failures entirely, and the more complex a system is the more difficult it is to identify and predict where and when failures will occur. The presence of a latent failure can give otherwise innocuous actions and behaviors a greater potential for harm. Given this, it is unsurprising that a large proportion of nursing error include a systemic cause or contributor (IOM, 2000). The need to provide accountability toward individual nurses along with the need to create a reporting environment where mistakes are widely reported and used as opportunities to learn is broadly referred to as “just culture.” More information on this topic is in *Appendix III: Just Culture*.

Indeed, individual error itself often has an underlying systemic contributory cause. A recent review of nursing care studies finds nurse well-being (operationalized as the level of stress, anxiety and depression, for example) and occupational burnout highly correlated with an increased risk of error and worse patient safety (Hall, Johnson, Watt, Tsipa, & O'Connor, 2016). Four important systemic sources of error are: (1) the level of nurse staffing and available time per patient, (2) the use of overtime to cover gaps, leading to burnout, (3) an organizational

culture that helps or hinders error avoidance, and (4) whether the implementation of nursing practice at a facility supports the cognitive needs of nurses.

*Staffing and Time per Patient*

One reason a nurse might decide against reporting an alleged violation by a colleague is if inadequate staffing contributed to the error. A number of studies point to concerns that nurses are often required to cover more patients than is optimal for patient health outcomes. There is evidence that the time a nurse is able to give per patient is associated with improved medical outcomes (Penoyer, 2010). Other studies find associations between nurse-to-patient ratios and/or time per patient with a number of health outcomes, such as a lower risk of central line associated bloodstream infections (CLBSI), ventilator-associated pneumonia, 30-day mortality, and bed sores (decubiti) (Stone P. , et al., 2007); decubiti (bed sores) (Blegen, Goode, & Reed, 1998; Unruh, 2003); infections (Amaravadi, Dimick, Pronovost, & al, 2000; Kovner & Gergen, 2007; Sovie & Jawad, 2001; Needleman, Buerhaus, Mattke, Stewart, & Zelevinsky, 2002); other outcomes (Blegen M. , 2006); and general patient survival (Aiken L. H., Clarke, M., & al, 2002; Blegen, Goode, & Reed, 1998).

Lucero, Lake and Aiken (2010) found a large proportion of surveyed nurses reported being

regularly unable to meet all nursing care requirements (Table 3). However, Some research has cast doubt on the robustness of these associations. Shekelle (2013) conducted a meta-analysis, and found that the bulk of the studies reporting an effect had substantial limitations. Among the studies they identified as “high-quality,” only a few could not rule out random chance as the cause of the observed data. Problems in publication bias toward positive results compound these results. In general, however, the literature links nurse ratios and health outcomes, and the larger issue is whether nurses themselves believe it to be true, and allow it to influence their decisions to report alleged violations.

*Overtime and Burnout*

Understaffing not only influences the time nurses are able to spend with individual patients, but also impacts the ability of nurses to do their job effectively, particularly when short staffs are covered through regular use of overtime. A number of recent nursing care studies find that nurse well-being generally (i.e. stress, anxiety, depression) and burnout specifically were found to be highly correlated with the increased risk of error and/or worse patient safety (Bogaert, Kowalski, Weeks, Van Heusden, & Clarke, 2013; Kirawn, Matthews, & Scott, 2013; Koy, Yunibhand, Angsuroch, & Fisher, 2015; Hall, Johnson, Watt, Tsipa, & O'Connor, 2016). As a result, nurses might be

*Table 3: Barriers to Adequate Nursing Care Reported by Registered Nurses*

Reported	Percent Reporting
Unable to consistently complete the development and/or updating of nursing care plans.	41%
Unable to provide adequate comfort and interaction with patients.	40%
Unable to provide needed back rubs/skin care.	30%
Unable to adequately teach patients and family.	29%
Unable to adequately document nursing care.	22%
Unable to provide oral hygiene for patients.	20%
Inadequate preparation of patients for discharge.	12%

less likely to report alleged violations if overwork or fatigue are contributing causes.

Nurses on 12-hour shifts get inadequate sleep and suffer from intershift fatigue—they do not fully recover between shifts, so they start each new shift with an increasing sleep deficit (Geiger-Brown, 2011). In surveys, nurses self-report higher rates of error due to fatigue from overtime (Rogers, Hwang, Scott, & al, 2004). Observational studies associate higher rates of catheter-associated urinary tract infections with decubiti [bedsores], for example (Stone P. , et al., 2007). Just working over 40 hours a week is associated with an increased rate of adverse events (Olds & Clarke, 2010).

There are caveats, however. The above studies are observational, and therefore it is difficult to draw definitive conclusions from them. For example, the same study that observed an increased risk of catheter-associated urinary tract infections and decubiti found a decreased risk of central line associated bloodstream infections (Stone P. , et al., 2007). Nonetheless, the preponderance of the literature shows that a nurse’s likelihood of error or of adverse patient outcomes correlates with the number of hours they work per day and per week.

### *Organizational Culture*

Even more generally, research shows that nurses’ perception of their workplace culture can be associated with improved patient outcomes and reduced likelihood of medical error (Braithwaite, Herkes, Ludlow, Testa, & Lamprell, 2017; Stone P. , et al., 2007). Effective and error-free clinical practice is not an individual effort, it relies on “social, cultural and organizational factors” much of which are outside of the individual nurse’s control (Patel, Kannampallil, & Shortliffe, 2015).

Nurses who feel empowered, through the support and respect of fellow nurses, doctors and supervisors, also report higher perceived

quality of care at their institutions (Breau & Rheume, 2014). If they report that they had opportunities to specialize and report reduced occurrences of “backfilling” duties, their perception of their work environment improves, and they report better patient safety outcomes (Breau & Rheume, 2014; Hopkins Duva & al, 2011). Awareness of the importance of organizational culture in nurse performance might also represent a mitigating factor that leads nurses to refrain from reporting alleged violations.

Much emphasis in this area of the nursing literature focuses on creating a “culture of safety” and “high-reliability organization.” Reason and Hobbes (Reason & Hobbs, Managing Maintenance Error: A Practical Guide, 2003) highlight three values embodied by high-reliability organizations: trust, reporting and improvement. When nurses trust their peers and the larger organization, they feel safe reporting mistakes without fear of unfair treatment. They also feel safe reporting unsafe conditions, without the fear of retaliation or “blaming the messenger.” Removing institutional barriers and disincentives against reporting, responding to reports quickly and widely communicating improvements establish trust. Chassin and Loeb (2013) argue that these three values create a self-reinforcing organizational culture.

These values are part of a larger shift among safety researchers away from error elimination and toward error recovery. Rather than requiring perfection, high-reliability organizations operate with the expectation that mistakes and errors will occur, and create systems to quickly recognize and recover from them before the errors result in adverse events. There is reason to believe that to do otherwise—focusing on the elimination of error, rather than identification and recovery—actually results in more error, and increases the

likelihood that errors will result in negative consequences (Patel, Kannampallil, & Shortliffe, 2015). Identifying individual responsibility is still a necessary part of such strategies, but the purpose is not to “pin the blame” or purely punitive. Even where there are individual causes of error they still need to be recognized as operating within a larger systemic context.

### *Cognitive Processing*

Organizational factors do not just influence propensity toward error through practices such as understaffing, overtime, insufficient training, or ineffective error monitoring. Safety researchers also recognize the importance of removing impediments to cognitive processing. Decades of research acknowledge the role of cognition in human and medical error (Reason, Human Error, 1992; Leape L. L., 1994).

Technology is often poorly adapted to human behaviors and processing models. The system forces humans to adapt to the technology, rather than the technology adapting to how humans think and work. This causes increased risk of error, particularly in high-stress environments (Norman, 2018). The typical response increases emphasis on training. Essential in fields where complex, but repetitive, tasks are common, training is also important where patients’ needs are changing and/or uncertain (Dekker, 2007). However, training itself can be a source of error. Highly trained clinicians are more prone to “premature closure,” a type of error where the first diagnostic hypothesis that fits is accepted rather than evaluating all possible alternatives (Patel, Kannampallil, & Shortliffe, 2015). This type of cognitive error can be difficult to identify because it so often does not result in an adverse event. Because they occur more frequently, some diagnostic hypotheses are easy to recall, meaning the use of such cognitive shortcuts results more often than not in a correct diagnosis. Premature closure resulting

in an incorrect diagnosis is therefore comparatively rare. As a result, a diagnostician can commit this error many times before it results in an adverse event.

When error detection systems are put in place there is added benefit in bringing the potential for errors like premature closure to the forefront of clinical practice, reducing the likelihood of committing these errors in the first place (Patel, Kannampallil, & Shortliffe, 2015). Organizations that focus on post-hoc punishment of individual error can actually reduce the ability of practitioners to achieve that goal.

Concerns about cognitive processing are somewhat abstract and not always raised with this precise wording. These issues often appear in the literature as a concern about inadequate and/or ineffective training or as poorly designed technology.

## **Options for Reporting Mechanisms**

Given these barriers to reporting, below are several options for “consistent and reasonable reporting mechanisms” for consideration.

### **Continue Current Reporting Practices**

One approach to employer reporting is to maintain the current policy of voluntary reporting. Approximately a third of states have no mandatory reporting for registered nurses, including California.

Healthcare professional culture safeguards patient health by reporting dangers to patient safety. This is particularly true within the nursing profession, where the patient-centered tradition is a source of individual and collective pride. This explains why nurses report patient care violations at a comparatively higher rate compared to other medical professions (Wolf & Hughes, 2008).

In fact, there does not appear to be a strong difference in reporting between states with voluntary regimes, states with mandatory employer reporting or states with some other form of mandatory licensee reporting. The experience of Connecticut’s HAVEN program—which saw a 30 percent increase in enrollment when the state first adopted mandatory reporting rules—indicates some instances of underreporting in substance abuse or mental illness, though it is possible there are other explanations for the increase.

### *Expand Training and Outreach*

Many barriers to reporting described by nursing administrators were due to uncertainty and lack of training. As enumerated in Table 3 above, managers said that uncertainty about which behaviors were potentially reportable violations to the board made them less likely to notify their state board. This offers an opportunity to capture unreported violations by expanding outreach provided on the California Nursing Practice Act, focusing on identifying violations and how best to report them. Recognizing this need, the Nursing Board has already increased outreach this past year, providing enforcement presentations to hospital staff as well as to deans and directors of nursing schools (California Board of Registered Nursing, 2018).

Beyond presentations, adopting tools similar to the Complaint Evaluation Tool used by North Carolina and Oregon could also provide clearer and objective guidelines on when and how to report potential violations. Expanding these activities into a formal outreach program extends their impact, and helps guarantee their continuance across board administrations.

### **Mandatory Reporting for Alleged Violations of the Nurse Practice Act**

Mandatory reporting states vary regarding who is required to report: employers, fellow registered nurses, or, more broadly, all licensed

medical professionals. States with mandatory employer reporting provisions also vary according to criteria that trigger a mandatory report. Least restrictive versions only require employers to report dismissals, suspensions, or “resignations in lieu of dismissal” resulting from alleged violations. Draft language in SB 799 adopted this less restrictive approach. Earlier versions required employer reporting in the case of “the suspension or termination for cause, or resignation for cause, of any registered nurse in its employ.” This level of mandatory reporting gives the facility leeway to provide internal discipline and training without requiring a report to the board that triggers an investigation, so long the nurse is not suspended, terminated or resigns.

States with more restrictive rules require employers to report if violations result in the imposition of restrictions on a nurse, or if other internal discipline is used, such as requiring supplemental training or placing additional oversight on the licensee. The strictest form of employer reporting requires reporting by the employer if they are aware of any practice act violations by a nurse they employ. Mandatory reporting rules that cover nurses or other licensed professionals are generally of this broader type, but sometimes limited by severity or type of reportable violation. Some states have narrower reporting requirements, only mandating a report if the nurse is fired due to an alleged violation. It is possible increased reporting requirements could be used as a retaliation or bullying tool. The literature indicates this most likely occurs in organizations with quasi-formal disciplinary processes, rather than in organizations with highly formalized mandated reporting structures. However, while mandatory reporting potentially reduces opportunity for arbitrary punishment, it also may worsen the impacts of retaliation when it does happen (See *Appendix IV: Management*

*Bullying and Retaliation in Nursing* for more information.)

To the extent stricter reporting requirements capture alleged violations otherwise unreported, they are also more likely to capture

complaints of lower severity, and concomitantly, of lower priority for the board. Unfortunately, limited resources dictate that lower-severity complaints potentially go uninvestigated because staff focuses, by necessity, on higher-severity violations.

## Appendices

### Appendix I: Detailed Table

Table A-4: Mandatory Reporting Rules, License Counts (2017), and Complaints (2017), by State

State	Employer	Registered Nurse	Other Practitioner	RN Licenses	LPN/LVN Licenses	Total	Complaints
AL	○	●	○	79,610	18,486	98,096	1,525
AK	●	○	○	13,829	865	14,694	64
AZ	○	○	○	87,420	10,362	97,782	1,000
AR	○	○	○	41,636	15,287	56,923	1,904
CA*	○	○	○	427,892	NA	427,892	7,757
CO	●	○	○	75,419	8,712	84,131	876
CT	●	●	●	64,882	12,956	77,838	NA
DE	○	●	●	18,111	3,050	21,161	NA
FL	○	●	●	316,640	NA	316,640	2,637
GA	●	●	○	132,949	30,813	163,762	1,581
HI	○	○	○	NA	NA	NA	NA
ID	○	●	○	21,362	3,747	25,109	NA
IL	○	○	○	195,399	26,820	222,219	NA
IN	○	○	○	111,129	25,385	136,514	NA
IA	○	○	○	54,415	10,517	64,932	779
KS	○	○	○	57,969	10,639	68,608	2,060
KY	●	●	●	69,753	13,835	83,588	1,840
LA*	○	●	○	65,914	NA	65,914	1,164
ME	○	○	○	25,026	2,242	27,268	361
MD	●	●	○	81,363	12,297	93,660	NA
MA	○	○	○	134,405	20,488	154,893	NA
MI	○	○	○	149,864	24,237	174,101	1,673
MN	●	●	●	109,456	22,297	131,753	1,106
MS	○	●	○	48,907	14,222	63,129	NA
MO	●	○	○	108,321	25,375	133,696	2,354
MT	○	○	○	16,285	2,663	18,948	235
NE	○	○	○	29,930	5,842	35,772	583
NV	○	●	●	38,054	3,905	41,959	705
NH	●	●	○	22,777	3,130	25,907	142
NJ	●	●	○	124,991	23,435	148,426	343
NM	○	●	○	28,422	2,758	31,180	343
NY	●	○	○	322,755	76,928	399,683	NA
NC	○	○	○	134,738	22,605	157,343	1,448
ND	●	●	○	14,039	3,161	17,200	105
OH	●	○	○	204,281	54,720	259,001	8,710
OK	○	●	○	55,506	16,808	72,314	504
OR	●	●	○	60,230	5,381	65,611	NA
PA	○	○	○	220,583	53,989	274,572	NA
RI	○	○	○	20,529	2,008	22,537	NA

Employer Reporting Practices for Registered Nurses

SC	●	●	○	69,799	12,682	82,481	NA
SD	○	○	○	18,162	2,617	20,779	196
TN	○	●	○	100,817	30,216	131,033	NA
TX	●	●	○	314,920	105,655	420,575	NA
UT	●	●	●	33,309	2,834	36,143	NA
VT	●	●	○	14,064	2,379	16,443	NA
VA	○	○	○	104,667	27,745	132,412	5,639
WA	●	●	●	96,664	11,513	108,177	NA
WV*	○	●	○	32,669	NA	32,669	NA
WI	○	●	○	102,908	13,166	116,074	NA
WY	○	●	○	15,579	1,465	17,044	NA

\* Board regulates Registered Nurses only.

## Appendix II: NC Complaint Evaluation Tool

Also available online at: <https://www.ncbon.com/vdownloads/ce-tool.pdf>

### North Carolina Board of Nursing (NCBON) COMPLAINT EVALUATION TOOL (CET)

Allegation(s): \_\_\_\_\_ Licensee Name: \_\_\_\_\_

Criteria	Behavior					Score
	Human Error 0	1	2	3	Reckless Behavior 4 5	
<b>G</b> General Nursing Practice	No prior written counseling for practice issues.	Prior written counseling for single non-related practice issue within last 12 months.	Prior written counseling for single related practice issue within past 12 months	Prior written counseling for various practice issues within the last 12 months	Prior written counseling for same practice issue within last 12 months	Prior written counseling for same or related practice issue within last 6 months with minimal to no evidence of improvement
<b>U</b> Understanding / experience	Has knowledge, skills, and ability. Incident was accidental, inadvertent or oversight.	Limited understanding of correct procedure. May be novice < 6 months experience in nursing or with current event / activity.	Unlimited understanding of options / resources. Aware of correct procedure but in this instance not corners. May be advanced beginner – 6 months to 2 years experience in nursing or with current event / activity.	Aware of correct action / rationale but failed to apply in this incident. Did not obtain sufficient information or utilize resources before acting. May be competent > 2 years experience in nursing or with current event / activity.	In this instance there was intentional negligence or failure to act / not act according to standards. Risk to client outweighed benefits. May be in a position to guide / influence others. May be proficient > 5 years in nursing or with current event / activity.	In this instance there was intentional gross negligence / unsafe action / inaction. Licensee demonstrated no regard for client safety and harm almost certainly would occur. May hold a leader / mentor position. May be expert performer > 5 years in nursing or with event / activity.
<b>I</b> Internal policies / standards / orders	Policy / standard / order has not been enforced as evidenced by cultural norm (common deviation of staff) or policy / standard / order was misinterpreted.	Policy / standard / order clear but nurse deviated in this instance as a time saver. Failed to identify potential risk for client. No evidence of pattern.	Aware of policy / standard / order but ignored or disregarded to achieve perceived expectations of management, client, or others. Failed to utilize resources appropriately. May indicate a pattern.	Intentionally disregarded policy / standard / order for own personal gain.	Intentional disregard of policy / standard / order with understanding of negative consequences for the client.	
<b>D</b> Decision / choice	Emergent situation – quick response required to avoid client risk.	Non-emergent situation. Chose to act / not act because perceived advantage to client outweighed the risk.	Emergent or non-emergent situation. Chose to act / not to act without weighing options or utilizing resources. Used poor judgment.	Clearly a prudent nurse would not have taken same action. Unacceptable risk to client / agency / public. Intentional disregard for client safety.	Willful / reckless / flagrant choice. Put own interest above that of client / agency / public. Intentionally neglected red facts. Substantial and unjustifiable risk.	
<b>E</b> Ethics / credibility / accountability	Readily admitted to error and accepted responsibility when questioned. Identified opportunities and plan for improvement in own practice.	Reluctantly admitted to error but attributed to circumstances to justify action / inaction. Cooperative during investigation and demonstrated acceptance of performance improvement plan.	Denied responsibility until confronted with evidence. Blamed others or made excuses for action / inaction. Failed to see significance of error. Reluctantly accepted responsibility and denied need for corrective action.	Denied responsibility despite evidence. Indifferent to situation. Uncooperative, insubordinate and / or dishonest during investigation.	Took active steps to conceal error or failed to disclose known error. Provided misleading information during investigation or destroyed evidence. May have inappropriately confronted others regarding investigation.	

Criteria Score

**North Carolina Board of Nursing (NCBON)  
COMPLAINT EVALUATION TOOL (CET)**

Mitigating Factors -check all identified	Aggravating Factors - check all identified
Communication breakdown (multiple handoffs, change of shift, language barrier)	Took advantage of leadership position
Limited or unavailable resources (inadequate supplies / equipment)	Especially heinous, cruel, and / or violent act
Interruptions / chaotic environment / emergencies – frequent interruptions / distractions	Knowingly created risk for more than one client
Worked in excess of 12 hours in 24 / or 60 hours in 40 to meet agency needs	Threatening / bullying behaviors
High Work volume / staffing issues	Disciplinary action (practice related issues) in previous 13 – 24 months
Policies / procedures unclear	Vulnerable client geriatric, pediatric, mentally / physically challenged, sedated
Performance evaluations have been above average	Worked in excess of 12 hours in 24 / or 60 hours in 40 to meet personal needs
Insufficient orientation / training	Other (identify)
Client factors (combative / agitated, cognitively impaired, threatening)	
Non-supportive environment – interdepartmental conflicts	
Lack of response by other departments / providers	
Other (identify)	
<b>Total # mitigating factors identified</b>	<b>Total # aggravating factors identified</b>

Criteria Score from page 1 \_\_\_\_\_

No Board Contact Required	Board Consultation Required	Board Report Required
Contact with NCBON is not required if: <ul style="list-style-type: none"> <li>o 3 or more criteria in green <u>OR</u></li> <li>o Criteria score of 6 or less</li> </ul>	Consult with NCBON if: <ul style="list-style-type: none"> <li>o 3 or more criteria in yellow <u>OR</u></li> <li>o Criteria score 7 – 15</li> </ul> Call- 919-782-3211 ext 256 or 226	Mandatory report to NCBON if <ul style="list-style-type: none"> <li>o 2 or more criteria in red <u>OR</u></li> <li>o Criteria score 16 or more <u>OR</u></li> <li>o Incident involves fraud, theft, drug abuse, diversion, sexual misconduct, mental / physical impairment.</li> </ul> Go to website: ( <a href="http://www.ncbon.com">www.ncbon.com</a> ) or Call 919-782-3211 ext 282 for assistance

CET Completed by : \_\_\_\_\_ Facility Name: \_\_\_\_\_

Contact Number & Email address: \_\_\_\_\_

Date of Consultation with NCBON \_\_\_\_\_ NCBON Consultant: \_\_\_\_\_ Action Taken: \_\_\_\_\_

2011 – Version 2.0 @ NCBON-Permission Required Before Use

## Appendix III: Just Culture

In the 1970s, researchers started making greater effort to understand causal models of medical error. The primary driver behind this research was a growing concern around increasing medical malpractice lawsuit rewards (Hiatt & al., 1989). It had become clear that the current malpractice insurance system exposed insurers to significant liability and/or would require increased insurance premiums dramatically above what doctors were used to paying, or could afford. Much of what researchers now know about the sources of medical error came out of this literature. The most widely cited of such studies was the Harvard Medical Practice Study, the results of which were first published by the *New England Journal of Medicine* in 1991 (Brennan & al., 1991). The Harvard study drew “a weighted sample of 31,429 records of hospitalized patients from a population of 2,671,863 non-psychiatric patients discharged from [51] nonfederal acute care hospitals in New York in 1984.” The researchers then used this sample to estimate an overall rate of adverse events, and further estimated the proportion of medical injuries that were the result of negligent or otherwise substandard care. Of the original 31,429 records sampled, the researchers identified 1,278 hospitalizations with at least one adverse event. Of those, 306 were determined to have occurred due to negligence or substandard care.

When researchers weighted and adjusted those numbers to match the broader patient population in New York State, they estimated that approximately 3.7 percent (with a 95 percent confidence interval of 3.2 percent and 4.2 percent) of hospitalizations result in an adverse event. They further estimated that 1.0 percent (95 percent confidence interval of 0.8 percent to 1.2 percent) of hospitalizations result in hospitalizations that were due to negligence

or substandard care. This implies that the largest portion—73.0 percent—of adverse events occurred without evidence of negligence. An earlier—but smaller—California study found similar results (Mills, 1987).

Ten years after the Harvard Medical Practice Study, the Institute of Medicine’s (IOM), Quality of Health Care in America Committee published *To Err is Human*, produced with the goal of identifying the causes of medical error and providing effective strategies to reduce them. One key conclusion of the report was that the majority of medical errors were not the result of an individual or group’s recklessness (IOM, 2000). In other words, eliminating “bad apples” and/or maintaining more stringent standards of practice would not eliminate more preventable adverse events:

“More commonly, errors are caused by faulty systems, processes, and conditions that lead people to make mistakes or fail to prevent them.... [M]istakes can best be prevented by designing the health system at all levels to make it safer—to make it harder for people to do something wrong and easier for them to do it right. Of course, this does not mean that individuals can be careless. People still must be vigilant and held responsible for their actions. But when an error occurs, blaming an individual does little to make the system safer and prevent someone else from committing the same error.”

To the extent that disciplinary action is primarily punitive—i.e. fear of consequences is meant to deter lax behavior—safety researchers have argued that such punishment is ineffective in cases where most (if not all) practitioners would have made the same mistake (Miller B. , 2008; Miller, Griffith, & Vogelsmeier, 2010). Even in cases where readily identifiable human error

occurred and contributed to an adverse event, it can be more valuable to identify the systems that failed to recognize and prevent the error (Whittingham, 2003; Kerfoot, 2008). Focusing on individual punishment also carried the risk of forestalling needed systemic improvements. If there are systemic contributions to the medical error, prioritizing the identification of the individual(s) to blame can lead to premature closure. This is a cognitive error where the first viable explanation is adopted, preventing the full consideration of alternative explanations. Once an individual has been blamed, and the disciplinary process is underway, additional causes can be overlooked—and therefore any systemic issues that contributed to the error will remain uncorrected (Ebright & Rapala, 2003).

These concerns are often cited by the many studies that focus on organizational changes to reduce medical error, and improve patient safety. There is a significant body of literature that has identified replacing the punitive culture with a culture of safety as the most important piece of effective patient safety policy (Wolf & Hughes, 2008; Force, Deering, Hubbe, & al, 2006; Stump, 2000; Boysen, 2013). This shift away from a pure punitive approach began about the same time that the healthcare industry began reducing individual autonomy in healthcare provision, shifting away from one that emphasized the individual professional role toward a more systematized group care model. This occurred largely because of changes to the industry outside of the patient safety-medical error purview—primarily the changes were a response to increasing medical costs and the emergence of HMOs and industry consolidation to control costs. But whatever the impetus, the result was a reduction in individual autonomy for licensed health providers, a change which effected nurses to a significant degree (Boysen, 2013). In this new environment, systemic concerns are more important than ever.

Importantly, when surveyed, most hospital leaders reported that mandatory reporting to nursing boards deters reporting patient safety incidents to internal reporting systems. They were also concerned that the non-confidential nature of such systems could also encourage lawsuits (Weissman, Annas, Epstein, & al, 2005). Patients, on the other hand, support mandatory reporting (Blendon, DesRoches, Brodie, Benson, & al, 2002).

In response to these divergent and opposing concerns, the patient safety community has coalesced around a series of policy preferences and cultural values called “just culture.” Just culture attempts to balance the need to provide accountability toward individual nurses with the need to create an environment where mistakes are widely reported and learned from (Marx, 2001; Miller B. , 2008; Kerfoot, 2008). It draws heavily from the “highly reliable organizations” model, building on the key concepts that: 1) human error cannot be avoided 100 percent of the time, 2) even well-designed organizational systems can fail, and 3) risk is everywhere.

The IOM (2000) report recommended adopting mandatory reporting, but with an emphasis on adverse events resulting in serious harm or death. Recognizing that mandatory reporting systems involved both learning and accountability mechanisms, it suggested conducting “root cause” analyses of the health delivery system as a whole. Under such an approach, individual blame—and ultimately board discipline—is contingent on whether the individual error was the root cause of the practice breakdown, and whether error is due to 1) unavoidable human error, 2) at-risk behavior, or 3) reckless behavior (Boysen, 2013).

A number of state boards of nursing embrace approach. Ohio’s Board of Nursing explicitly adopted just culture principles in its “Patient Safety Initiative” (Ohio Board of Nursing).

Ohio's goal is to improve overall reporting of error, create a statewide patient safety database, and improve opportunities for employer-sponsored remediation and alternative discipline programs. Missouri's "Just Culture Collaborative" places focus on learning and implementing the principles of just culture (Miller, Griffith, & Vogelsmeier, 2010). The collaborative currently has 67 members, including business, government and professional associations. California took similar steps. Formed in 2007, the California Patient Safety Action Coalition introduced state healthcare leaders to just culture. Active for a number of years, they ultimately felt they met their educational goals and have since disbanded. While no organization in California is currently dedicated to advancing just culture, the California Hospital Patient Safety Organization invests resources and works in this area.

## Appendix IV: Management Bullying and Retaliation in Nursing

Punishment models in an employer-employee context, historically, increase the “docility” of the workforce (Knight & Latreille, 2000). Nurses, expected to be advocates for their patients, may at times find themselves in opposition to managers and employers. Discipline that punishes nurses’ fulfilling their role as patient advocates causes the disciplinary process to work at odds with patient health outcomes. A rhetoric of correction, then, could effectively mask punishment. This is a recognized phenomenon within professional nursing (Fenley, 1998; Cooke, 2006).

The larger workplace retaliation literature offers helpful detail. The typical pattern for workplace retaliation is for punishment to take place through small repetitive acts, occurring over an extended period, often with escalating harassment (Glasø, Løkke Vie, & Hoel, 2010). Typically, retaliatory acts do not come from a single individual, but from diverse sources (Miceli, Near, & Dworkin, 2008). Coworkers, even those sympathetic, add to isolation felt by targeted individuals when they pull away from professional and personal relationships to avoid being targeted themselves (Beardshaw & Thorold, 1981, p. 37; Bjørkelo & Matthiesen, Preventing and Dealing with Retaliation Against Whistleblowers, 2011).

Retaliatory bullying creates significant additional stressors in the work environment (Wilson, 1991; Adams & Crawford, 1992; Zapf, Knorz, & Kulla, 1996), with negative consequences for physical health (Soeken & R., 1987), psychological health (Rothschild & Miethe, 1999), and triggers symptoms analogous to post-traumatic stress disorder (Bjørkelo, Ryberg, Matthiesen, & Einarsen, 2008). When workplace retaliation includes reports to a state nursing board, the potential for such stress increases. Lodging a complaint

has an “immediate and devastating impact on their feelings about nursing and their confidence in their professional skills” (Beardwood & French, 2004). If the complaint results in practice restrictions, the impacts on a nurse’s career and personal well-being are profound. A recent review of Australian nursing boards shows that reports coming from one’s employer are taken more seriously and have a higher likelihood of resulting in discipline (Spittal, Studdert, Paterson, & Bismark, 2016).

One concern about instituting mandatory reporting employer reporting requirements is its potential to influence the ability of managers to punish and retaliate against nurses for workplace organizing or for reporting for quality of care violations. Existing research does not specifically address this issue. Cooke (2006), however, points out that such use of punishment for worker-management disagreement is most common where the disciplinary processes are quasi-formal. In these situations, managers apply standard of care criteria more aggressively on targeted individuals than on staff as a whole. When managers have less discretion in when and how to apply discipline, the potential to use the disciplinary process for retaliation is more limited. If accurate, research indicates mandatory reporting reduces the amount of discretion managers have, therefore reducing their ability to target specific nurses for retaliation. However, while mandatory reporting potentially reduces the opportunity for arbitrary punishment, it could also worsen impacts of retaliation when punishment happens.

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