

## REPORT OF THE EXECUTIVE DIRECTOR

### NATIONAL ISSUES

**Article on Medication Errors in Nursing Homes.** Dr. Jill Scott-Cawiezell from the University of Missouri-Columbia has published an article, "Nursing Home Error and Level of Staff Credentials" in Clinical Nursing Research, Vol. 16, No. 1, 72-78 (2007). This article contains data from an observational study where administration of medications by RNs, LPNs and medication assistants are compared. The study concludes that when medication assistants are adequately trained and supervised, there are no significant differences in error rates. Dr. Scott-Cawiezell is conducting additional research on medication error rates with 16,000 medication administrations observed. At the 2007 Delegate Assembly of the National Council of State Boards of Nursing (NCSBN), model medication assistant curriculum and decision to proceed with development of a national medication aide competence assessment were approved. **(See Attachment A).**

**Article on the HASP Project:** Mary Beth Thomas, PhD, RN, Debora Simmons, RN, MSN, CCRN, CCNS, et. al. published an article, "Practice/Regulation Partnerships: The Pathway to Increased Safety in Nursing Practice, Health Care Systems, and Patient Care", in the American Organization of Nurse Executives' Journal Nurse Leader about the HASP pilot project. This is an opportunity to share with Nurse Executives around the country the investment of a board of nursing in a project that helps to better identify system issues and improve patient safety. **(See Attachment B).**

**APRN Joint Dialogue Group:** Two professional groups, the NCSBN APRN Committee and the APRN Consensus Group, separately identified the need to move to a future model for regulation and worked concurrently to develop an effective and efficient APRN regulatory model for public protection. As these groups continued their work in a parallel fashion, concerns regarding the need for collaboration and congruent outcomes between the two groups were expressed by both groups. A subgroup of the APN Consensus Group and of the NCSBN APRN Committee was convened in January, 2007. The group called itself the APRN Joint Dialogue Group and the agenda consisted of discussing areas of agreement and disagreement between the two groups. This group continues to meet to discuss and resolve issues of concern.

### STATE ISSUES

**Health Professions Council:** HPC discussed at its last meeting a new Human Resources Job Screening pilot program to assist HPC agencies with posting job openings and screening applicants, and assisting new employees with filling out required state employment paperwork. Expansion of this project to include other human resource functions is currently being explored.

The Governor's Office is conducting a Business Process Review of administrative functions for HPC agencies with the goal of recommending consolidation of functions to HPC at a future HPC meeting.

**State Surplus:** The Comptroller reports that the State ended the 2007 fiscal year with a \$8.5 billion surplus, \$1.5 billion more than projected in January. The surplus is attributed to state sales and use tax collections. Some of the extra money will be used to fund contingency appropriations, including state employee raises of 2% per year for the biennium. Some of the money will carry forward to the 2009 Legislative session where the 2010-2011 budget will be adopted.

## **BOARD ISSUES**

**New Stipulation Added:** A course in “Sharpening Critical Thinking Skills,” a 3.6 contact hour online program provided by the National Council of State Boards of Nursing (NCSBN) Learning Extension has been added to the stipulation options and is being recommended for certain practice violations where critical thinking skills may need improvement.

**Question on Criminal History Changes:** The question on criminal history has changed to make it clearer to applicants/petitioners/nurses what they must disclose. **(See Attachment C).**

**BNE Bulletin Articles:** The October issue of the *Board of Nursing Bulletin* contains an article soliciting memorabilia from nursing history for the 100<sup>th</sup> anniversary, articles recognizing Mark Majek and Linda Rounds awards/accomplishments, and an article on Cindy Smith’s research on criminal background checks by the Board.

**Board Development:** Generally, at each board meeting, a board development session is held. At this Board meeting Mary Beth Thomas will present her dissertation , “Perception of Registered Nurses Sanctioned by a Board of Nursing: Individual, Health Care Team, Patient, and Systems Contributions to Error”.

**October Board Meeting:** A retreat will be held on Tuesday afternoon and Wednesday at the Hilton Garden Inn Austin Downtown. Action items related to implementation of the Sunset bill (HB 2426) will be discussed.

**New Board Members:** There is no news of new board member appointments at this time. Because of the proximity to the Board meeting, the requirement to orient new members prior to attendance at meetings, and the commitment to attend the retreat and Board meeting (4 days), it seems unlikely that new members will be able to attend the October meeting even if appointed.

## **AGENCY ISSUES**

**Staff:** Karen Neighbors is our new educational consultant replacing Betty Simms. She comes to us from Trinity Valley Community College in Kaufman, Texas where she served as the Vocational Nursing Program Coordinator since 2001. She has worked for Trinity Valley Community since 1997. During her tenure as a nursing educator, she also worked as a PRN staff nurse at Presbyterian Hospital in Kaufman because she values staying current in practice.

We are very happy that she has moved to Austin to work with us. She is currently working on her Masters degree and expects to be finished in June 2009. She is providing our educational team with vocational nursing expertise and will be invaluable in our work with vocational programs.

In July, performance evaluations were completed for staff and merit salary increases and administrative leave were awarded for those who earned them.

Staff Training: EEOC training sessions for general staff and supervisors were conducted by outside consultant in August.

**Website:** The website has been updated to reflect to official name change of the Board and to incorporate additional photos on some pages. The new Nursing Practice Act is being formatted and will be added to the website soon.

**Key Meetings and Presentations:** I have attended/presented at the following meetings since the last Board meeting:

- *Visit:* Louisiana Board of Registered Nursing staff visited the Board to learn more about our disciplinary and investigative processes, July 26-27, 2007.
- *Conference Call:* Planning meeting for NCSBN Meeting with APRN Approvers and Certifiers, August 1, 2007.
- *Conference Call:* APRN Advisory Committee meeting, August 3, 2007.
- *Meeting:* Nurse Licensure Compact Administrators, August 6, 2007, Chicago.
- *Meeting:* National Council of State Boards of Nursing Annual Meeting and Delegate Assembly, August 7-10, 2007, Chicago.
- *Meeting:* State Agency Nursing Leadership, August 13, 2007, Austin.
- *Meeting:* with Governor's Office Staff, August 13, 2007, Austin.
- *Meeting:* with representatives of the Texas Consortium of Certified Nurse Midwives, August 17, 2007, Austin.
- *Meeting:* with APRN Accreditors and APRN Advisory Committee, August 22, 2007, Chicago.
- *Meeting:* with APRN Certifiers and APRN Advisory Committee, August 23, 2007, Chicago.
- *Conference call:* with Chair of the NLCA and NCSBN staff to discuss the Drug Enforcement Agency (DEA) requirements for APRNs to have DEA numbers in Compact states, August 30, 2007.
- *Meeting:* with Nancy Mabijs from the Galen Institute to discuss their program development status, August 31, 2007, Austin.
- *Meeting:* with Dr. Mary Hoke from New Mexico State University to discuss their APRN program and eligibility of their graduates for approval in Texas, September 6, 2007, Austin.
- *Meeting:* with Donna Howard to discuss status of Sunset implementation, September 7, 2007, Austin.

- *Meeting:* Health Professions Council, September 10, 2007, Austin.
- *Meeting:* with Dr. Ben G. Raimer (UTMB Correctional Managed Care), Dr. Lannette Linthicum (Texas Department of Criminal Justice), and Dr. Denise DeShields (Texas Tech Correctional Managed Care) to discuss correctional care and related nursing issues, September 10, 2007, Austin.
- *Presentation:* Board of Nursing Implementation of Sunset Bill, Texas Nurses Association Leadership Conference, September 20, 2007, Austin.
- *Meeting:* with Mark Levin from Texas Public Policy Foundation to discuss Board policy on criminal convictions, September 21, 2007, Austin.
- *Meeting:* State Agency Nursing Leadership, September 24, 2007, Austin.
- *Conference Call:* Nurse Licensure Compact Administrators, October 9, 2007.

## LVN DISCIPLINARY ORDERS AND ENDORSEMENTS

Time frame: July 1, 2007, through September 30, 2007

<b>DISCIPLINARY</b>	
27	<p><b>FINE WITH REMEDIAL EDUCATION</b></p> <ul style="list-style-type: none"> <li>12 Non disclosure/disclosure of Criminal History on Renewal Application/Random Audit</li> <li>11 Practicing without a valid nursing license</li> <li>1 Delegated assignments to unqualified staff</li> <li>1 Accepted assignment outside scope of practice</li> <li>1 Disciplinary action taken by another licensing authority</li> <li>1 Non compliance with Continuing Education Audit</li> </ul> <hr style="width: 100%;"/> <p>27</p>
15	<p><b>REMEDIAL EDUCATION</b></p> <ul style="list-style-type: none"> <li>2 Practicing without a valid nursing license</li> <li>2 Non disclosure of Criminal History on Renewal Application</li> <li>1 Administered medication without a physicians order</li> <li>1 Failed to document the withdrawal and wastage of a medication</li> <li>1 Neglected to inform TDFS that shew as married to the mental health worker being reported for abuse</li> <li>1 Inappropriately applied a discontinued medication to a wound</li> <li>1 Verbally and Emotionally abusive to a resident</li> <li>1 Failed to initiate proper nursing interventions</li> <li>3 Failed to administer medications as ordered</li> <li>1 Administered in error, ten times the ordered dosage of medication</li> <li>1 Failed to notify physician of patient status change</li> </ul> <hr style="width: 100%;"/> <p>15</p>
23	<p><b>VOLUNTARY SURRENDER</b></p> <ul style="list-style-type: none"> <li>14 Submitted a statement of Voluntary Surrender</li> <li>2 Non compliance with previous Board order</li> <li>1 Filled out pre-signed triplicate prescriptions for controlled substances</li> <li>1 Misappropriation and Intemperate use of Morhpine</li> <li>1 Attempted suicide</li> <li>1 Intemperate use of Alprazolam, Morphine, Oxycodone, and Meperidine</li> <li>1 Intemperate use of Cocaine; felony offense of Possession of a Controlled Substance</li> <li>1 Obtained fraudulent prescriptions for Hydrocodone; Intemperate use of Opiates</li> <li>1 Practice nursing without a valid license; felony offense of Engaging in Organized Crime</li> </ul> <hr style="width: 100%;"/> <p>23</p>
12	<p><b>TPAPN BOARD ORDER</b></p> <ul style="list-style-type: none"> <li>1 Intemperate use of Cocaine</li> <li>1 Misappropriation of 500 tablets of Norco; Intemperate use of Norco, Hydrocodone, Oxycodone, Percodan, and Tylenol</li> <li>1 Intemperate use of Amphetamines</li> <li>1 Misappropriation of 60 hydrocodone tablets</li> <li>1 Intemperate use of Amphetamine, Methamphetamine, Marijuana, and Cocaine</li> <li>1 Misappropriation and Intemperate use of Demerol</li> <li>1 Passed 202 unauthorized prescriptions for dangerous drugs and controlled substances</li> <li>1 Misappropriation and intemperate use of Hydrocodone and Xanax</li> <li>4 Lacked fitness to practice nursing safely</li> </ul> <hr style="width: 100%;"/> <p>12</p>

266	<p><b>APPLICANTS/ PETITIONERS</b></p> <ul style="list-style-type: none"> <li>1 Denial of Licensure</li> <li>1 Felony offense of Theft of Government Property</li> <li>1 State jail felony offense of Engaging in Organized Crime</li> <li>1 Misdemeanor offenses of Public Intoxication, Trespassing, and Driving Under the Influence</li> <li>1 Six counts of the misdemeanor offense of Theft by Check</li> <li>4 Felony offense of Securing Execution of Document by Deception</li> <li>1 Misdemeanor offenses of Theft, Theft by Check, and Driving While License Invalid</li> <li>1 Misdemeanor offenses of Resisting Arrest/Search/Transport, Theft of Property, and Assault</li> <li>5 Diagnosed with Bipolar Disorder</li> <li>1 State jail felony offense of Securing the Execution of a document by deception; misdemeanor Altering a Governmental Document</li> <li>2 Felony offense of Arson</li> <li>1 Seven counts of the misdemeanor offense of Theft by Check and one counts of Deposit Account Fraud</li> <li>1 Felony offense of Unlawful Possession of Food Stamp Coupons</li> <li>1 Felony offense of Manufacturing/Delivery/Sell/Possession of a Controlled Substance</li> <li>1 Felony offense of Possession with Intent to Distribute Marijuana</li> <li>1 Misdemeanor offenses of Theft by Check and two counts of Possession of Marijuana</li> <li>1 Offenses of Unlawfully Carrying a Weapon, Forgery, and Assault</li> <li>1 Two counts of the misdemeanor offenses of Minor in Possession and Public Intoxication</li> <li>1 Felony offense of Aggravated Assault, misdemeanor offenses of Possession of Marijuana, Evading Arrest, and Driving While Intoxicated</li> <li>1 Misdemeanor offenses of Assault, Theft by Check, and Possession of Marijuana</li> <li>1 Two counts of the misdemeanor offense of Driving While Intoxicated</li> <li>1 Felony offense of Aggravated Assault</li> <li>1 Felony offense of Burglary of a Building</li> <li>1 State jail felony offense of Possession of Marijuana</li> <li>1 Three counts of Public Intoxication and one count of Driving While Intoxicated</li> <li>1 State jail felony offense of Possession of a Controlled Substance</li> <li>1 Driving While Intoxicated and three counts of Possession of a Dangerous Drug</li> <li>1 State jail felony offenses of Possession of Cocaine and Possession of Controlled Substances</li> <li>1 Misdemeanor offenses of Theft of Property, Criminal Mischief, and Possession of Drug Paraphernalia</li> <li>1 State jail felony offense of Burglary of a Motor Vehicle</li> <li>22 Non disclosure of criminal history</li> <li><u>206</u> No Grounds for Denial/Youthful Indiscretion</li> <li>266</li> </ul>
40	<p><b>ENDORSEMENTS</b></p> <ul style="list-style-type: none"> <li>1 Denial of Licensure</li> <li>4 Disciplinary action taken by another licensing authority</li> <li>11 Non disclosure of criminal history</li> <li><u>24</u> No Grounds for Denial</li> <li>40</li> </ul>

## RN DISCIPLINARY ORDERS AND ENDORSEMENTS

Time frame: July 1, 2007, through September 30, 2007

<b>DISCIPLINARY</b>	
34	<p><b>FINE WITH REMEDIAL EDUCATION</b></p> <ul style="list-style-type: none"> <li>9 Non disclosure/disclosure of Criminal History on Renewal Application or positive Random Audit</li> <li>13 Non compliance with Continuing Education Audit</li> <li>1 Transferred a patient who had multiple medication problems</li> <li>11 Practiced without a valid nursing license</li> </ul> <p style="margin-left: 0;"><u>34</u></p>
18	<p><b>REMEDIAL EDUCATION</b></p> <ul style="list-style-type: none"> <li>1 Failed to inform DFPS that she was married to a mental health worker being investigated</li> <li>1 Failed to document the withdrawal, wastage, and witness of wastage of Lortab</li> <li>1 Admitted a patient to her hospice service without a physician's order</li> <li>1 Failed to adequately sedate a patient prior to administering a tube placement</li> <li>1 Submitted a home health visit note for a home health visit she did not make</li> <li>1 Failed to insure that in-service training covering modified diets was provided to staff</li> <li>1 Failed to timely submit documentation of scheduled skilled nurse visits</li> <li>4 Disciplinary action taken by another licensing authority</li> <li>3 Non disclosure/disclosure of Criminal History on Renewal Application or positive Random Audit</li> <li>4 Practiced without a valid nursing license</li> </ul> <p style="margin-left: 0;"><u>18</u></p>
16	<p><b>TPAPN BOARD ORDER</b></p> <ul style="list-style-type: none"> <li>1 Disciplinary action taken by another Licensing Authority</li> <li>1 Non disclosure/disclosure of Criminal History on Renewal Application or positive Random Audit</li> <li>1 Intemperate use of Alcohol, Dilaudid, and Cannabid</li> <li>1 Intemperate use of Nubain</li> <li>1 Misappropriation and Intemperate use of Dilaudid</li> <li>1 Intemperate use of Tramadol and Demerol</li> <li>1 Intemperate use of Marijuana</li> <li>2 Withdrew medications in excess of order</li> <li>1 Passed two hundred and two (202) unauthorized prescriptions for dangerous drugs and controlled substances</li> <li>1 Intemperate use of Methylphenidate and Propoxyphene</li> <li>5 Lacked fitness to practice nursing safely</li> </ul> <p style="margin-left: 0;"><u>16</u></p>
19	<p><b>VOLUNTARY SURRENDER</b></p> <ul style="list-style-type: none"> <li>1 Diagnosed depression to an all-time low and Respondent attempted to take her own life</li> <li>1 Disciplinary action taken by another Licensing Authority</li> <li>3 Non compliance with previous Board Order</li> <li>1 Failed to completely assess and intervene for a patient; patient was later found deceased in the restroom</li> <li>1 Intemperate use of Morphine, Demerol, and Versed</li> <li>1 Failed to assess and/or sufficiently document the change sin the deteriorating condition of a patient</li> <li>11 Submitted a statement of Voluntary Surrender</li> </ul> <p style="margin-left: 0;"><u>19</u></p>

39	<p><b>ENDORSEMENTS</b></p> <ul style="list-style-type: none"> <li>5 Disciplinary action taken by another licensing authority</li> <li>1 Denial of Licensure</li> <li>1 Four counts of Driving Under the Influence</li> <li>2 Felony offense of Theft</li> <li>1 Misdemeanor offense of Driving Under the Influence</li> <li>1 Felony offenses of Manslaughter and Criminally Negligent Homicide</li> <li>1 Felony offense of Possession of Marijuana</li> <li>15 Non disclosure of Criminal History</li> <li><u>12</u> No Grounds for Denial</li> </ul> <p><u>39</u></p>
230	<p><b>APPLICANTS/ PETITIONERS</b></p> <ul style="list-style-type: none"> <li>3 Denial of Licensure</li> <li>1 State jail felony offense of Tampering with Government Records, misdemeanor Hindering Apprehension</li> <li>1 Felony offense of Theft</li> <li>1 Misdemeanor offenses of Fleeing, Driving While Intoxicated - 2 counts, Disposal of Liter, and the felony offense of Driving While Intoxicated</li> <li>1 Misdemeanor offenses of Theft -2 counts, Zoning Violation - 2 counts, Operating a Vehicle Under the Influence, Theft by Shoplifting, and Failure to Appear</li> <li>1 Misdemeanor offense of Driving While Intoxicated and three counts of Possession of Dangerous Drugs</li> <li>1 Misdemeanor offenses of Public Intoxication - 2 counts, Minor in Possession - 3 counts, and Driving While Intoxicated</li> <li>1 Misdemeanor offenses of Minor in Possession, Driving While Intoxication, Public Intoxication, and Criminal Mischief</li> <li>3 Diagnosed with Bipolar Disorder</li> <li>1 Three counts of the misdemeanor offense of Theft</li> <li>1 Felony offense of Possession with Intent to Manufacturer</li> <li>1 Felony offense of Tampering with Government Records</li> <li>1 Misappropriation and Intemperate use of Benadryl</li> <li>2 Intemperate use of Alcohol</li> <li>1 Misdemeanor offense of Reckless Driving and Public Intoxication</li> <li>1 State jail felony offense of Possession of a Controlled Substance</li> <li>1 State jail felony offense of Reckless Homicide</li> <li>1 Offenses of Resisting Arrest, Driving Under the Influence, Driving While Intoxicated, and Possession of a Controlled Substance</li> <li>1 Two counts of the felony offense of Burglary of Habitation</li> <li>1 Felony offense of Securing Execution of Document by Deception</li> <li>8 Disciplinary action taken by another Licensing Authority</li> <li>1 Four misdemeanor offense of Driving While Intoxicated; one felony offense of Driving While Intoxicated, misdemeanor Theft by Check and Assault</li> <li>1 State jail felony offenses of Debit Card Abuse - 3 counts, Fraudulent Use or Possession of Identifying Information, Forgery - 4 counts and Possession of a Controlled Substance</li> <li>12 Non disclosure of Criminal History</li> <li>1 Felony offense of Credit Card Abuse</li> <li><u>182</u> No Grounds for Denial/Youthful Indiscretion</li> </ul> <p><u>230</u></p>

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## Nursing Home Error and Level of Staff Credentials

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Providing safe nursing home care is both a clinical and fiscal challenge in many countries. The fiscal realities result in the addition of other workers, such as medication technicians or aides (CMT/A), to the health care team. The purpose of this study was to determine the impact of various levels of credentialing among nursing home staff who deliver medications (RN, LPN, or CMT/A) on medication error. In addition, the impact of distractions and interruptions was explored. Using naïve observation, 39 medication administrators representing various levels of credentialing were unobtrusively observed to determine the number of medication errors, distractions, and interruptions in five nursing homes. There were no differences in medication error rates by level of credential. However, RNs had more interruptions during their medication administration, and these increased interruptions were associated with increased medication error rates when wrong time errors were excluded ( $p = .0348$ ).

**Keywords:** *medication error; naïve observation; opportunities for error; nursing credentials*

There is an increasing demand for nursing home services as many industrialized countries have an increasing proportion of their citizens among

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those 85 years old or greater. This demand comes in the midst of growing concern about the safety of health care. One aspect of safety, safe medication administration, is under close scrutiny as awareness increases about medication error (Barker, Flynn, Pepper, Bates, & Mikeal, 2002). Most nursing home residents have more illnesses, take more medications, and thus have more risk for adverse effects. The results of nursing home medication errors are subtle and can evolve slowly, often leading to greater consequences than have been reported in other settings (Bates et al., 1995; Gurwitz et al., 2005). Although the complexity of medication administration has been studied, little research has focused on nursing's role in medication administration and the unique challenges of administering medications in this setting. One such challenge to assuring safe medications administration is the varied levels of credentialing among staff who deliver medications.

Many countries are challenged both clinically and fiscally to provide safe nursing home care. More than 30 U.S. states and several industrialized countries are using alternative health care providers with minimal formal training to perform "routine" aspects of care. An example of these alternative health care providers is the certified medications technicians or aides (CMT/As) used to administer nursing home medications. Although CMT/As have administered medications for years in some U.S. states, there is limited evidence related to the impact of medication administrators' credentials on nursing home medication error. To date, the nurse-focused studies in nursing home medication studies have been limited to RNs and LPNs. In both an Australian study (Deans, 2005) and a U.S. study (Smith & Crawford, 2003), survey methods were used to elicit RNs' and LPNs' thoughts on what types of errors they had seen and/or made. In addition, they were asked what they believed contributed to the reported error. In both cases, interruptions and distractions were associated with the occurrence of medication error, and there were differences in the rates and types of medication errors reported by level of credential. Although the information does suggest many underlying and potential causes for error, experts in medication safety know that reported error is just the tip of the iceberg (Lambert, 2004).

Observational methods have been used by both the Centers for Medicare and Medicaid Services and other research teams to attempt to get to a more complete understanding of the prevalence of medication errors and the root causes of such errors (Barker et al., 2002; Pape et al., 2005; Pelletier, 2001). Using observational methods, differences have been noted in the frequency and type of errors between RNs and LPNs (Pelletier, 2001). To further explicate the differences among levels of staff credentialing, medication administration was observed to determine if differences existed among RNs', LPNs',

and CMT/As' rates of medication error and their frequency of distraction or interruption.

## Method

This descriptive and exploratory study used findings from naïve observation of medication administration that was completed during a larger Agency for Healthcare Research and Quality study funded to explore the impact of technology and focused quality improvement efforts on medication safety. The study was approved by the University of Missouri Institutional Review Board. This article reports on naïve observations prior to the implementation of technology. Site observations were conducted 3 to 4 days at each of the five sites across shifts and among various medication administrators. The five Midwestern nursing homes were a convenience sample of nursing homes willing to implement advanced technology within driving distance of the University of Missouri-Columbia. Although a convenience sample, the nursing homes represented both urban and rural settings that were small, medium, and large nursing homes and both profit and not-for-profit ownership, suggesting generalizability from the sample.

Naïve observation is an observation method that allows the nurse observer to unobtrusively observe a complete medication administration without preconceived ideas of what should be administered. The nurse observer walked with the medication administrator and watched the medication administration for each resident encounter, recording what medication was given, the dose, the route, the time, and any other noteworthy issues such as distractions or interruptions. The nurse observer avoided any contact with the medication administration record or medication orders until the observation was complete. At the end of the observation, the nurse observer compared the previous 90 days of the resident's medical record to determine if what was observed reflected active orders. The last 90 days of the resident record was used to ensure that the team could consistently get to medical record information that had not been archived.

Error was defined as a dose that was discrepant with the medication order. The rate of error was computed by dividing the number of doses with any discrepancy from the medication order (e.g., as wrong dose, wrong route, wrong resident) by the sum of the doses administered and the doses ordered to be administered. Distractions were defined as an event that did not stop the medication administration but could have diverted the medication administrator's attention, and interruptions were defined as events that

stopped the medication administration. Medication error was considered with and without wrong time medication error because wrong time error reflects many specific system and timing issues that are often out of the control of the medication administrator. To further explore the variables of interest, statistical comparison of error rates by credentialing was done using a generalized linear modeling package (GENMOD in SAS v9.1) to allow for modeling the dependencies in observations of the same medication administrators.

## Results

Five Midwestern nursing homes were the sites for the observations. The number of nursing home beds per site varied from 60 to 200. During the baseline observations time frame, 3,194 doses of medications were ordered to be given, including 3,101 doses observed and 93 omitted doses. Observations included 44 medication administrations for 907 resident encounters over 4,803 minutes. On average, a medication administration involved 73 medications (8 to 260 medications) and took an average of 113 minutes (25 to 245 minutes). The baseline observations involved 8 RNs (0-5), 12 LPNs (0-6), and 19 CMT/As (0-8). Although RNs had more years of experience (median of 13 years) when compared to the LPNs and CMT/As (9 and 3 median years, respectively), the CMT/As (median of 3 years) had more experience at the nursing home when compared to the RNs and LPNs (median for both less than a year).

Although RNs were 20.5% of the observations, they only administered 15.31% of the observed doses, whereas LPNs were 30.8% of the sample observed and gave 23.3% of the medications. Many of the medications delivered by the RN or LPN were related to specialized medication administrations such as insulin. CMT/As were 48.7% of the observations and administered 61.43% of the doses. When medication errors were considered by level of credential, RNs had an error rate of 34.6%, LPNs had an error rate of 40.1%, and CMT/As had 34.2% of their medications administered in error; however, when wrong time errors were removed, RNs had the largest percentage of error (7.4%). Despite the noted differences in medication error rates, there were no statistically significant differences by level of credential ( $p = .82$ ).

In addition to considering medication error rate, factors such as interruptions or distractions were also explored. More than 2,200 distractions or interruptions were observed. RNs had the highest percentage of interruptions (39.9%), whereas the LPNs had the highest percentage of distractions

(41.6%). To investigate the relationship between medication errors, distractions, or interruptions, Cochran-Mantel-Haenszel (CMH) statistical procedure was used. The CMH statistic assessed the association between variables after adjusting for the stratification on level of credential, thus allowing control for the effect of medication administrator. When considering the relationship between interruptions and the rate of medication error, it was interesting to note that although the relationship between interruptions and medication errors was significant with ( $p = .0099$ ) and without ( $p = .035$ ) wrong time errors, there was an inverse relationship between the rate of interruptions and medication errors when wrong time medication errors were included.

## Discussion

Cost-effective care is critical to nursing homes throughout the industrialized world. Cost-effective care requires using alternative types of health care providers such as CMT/As. The initial exploration of the impact of credentialing on medication errors rates would suggest that CMT/As are creating no greater risk for medication error. CMT/As actually had the lowest error rate (34.2%) when considering total medication error, whereas LPNs had the highest medication error rate (40.1%). Although there were no statistically significant differences in medication error by level of credential, RNs gave the least amount of medications (15.3%) and had the highest proportion of error without wrong time error included (7.4%).

Several factors may be contributing to this finding. First, although CMT/As had not been in their roles as long, the mean time in the nursing homes was longer for CMT/As (3 years), which suggests that they are more familiar with the medication system. The current Agency for Healthcare Research and Quality study also explored the differences among nursing home medications systems prior to the implementation of technology (Vogelsmeier, Scott-Cawiezell, & Zellmer, in press) and found that each system was truly unique in how information was conveyed and medications were packaged and dispensed. This suggests that being a "local" expert may enhance the staff members' ability to be effective.

Another difference among the levels of credentialing was the number of interruptions and distractions. There was a significant association noted between the rate of medication error and the number of interruptions when wrong time medication errors were excluded ( $p = .035$ ). Although this finding may appear in conflict with the earlier work that reported a link between medication errors and interruptions (Wakefield, Wakefield, Uden-Holman, &

Blegen, 1998), many studies have suggested that wrong time errors are the result of system problems such as too many residents and medications to be passed in the 2-hour time frame. Therefore, by considering the relationship without the systems issues of wrong time error, the real impact of interruptions may be clearly explicated, and our findings confirm the relationship between medication error and interruptions.

RNs had a higher rate of interruptions (39.9%) and the highest rate of medication error when wrong time errors were excluded (7.4%). The observations indicated that RNs were giving the medications that require more integration of clinical data such as insulin and accu-check readings. In addition, the CMT/As were not as involved in the other aspects of the residents' care, and neither were the CMT/As typically giving the "as needed" (PRN) medications. Both the complexity of the medications being delivered and the competing demands on the RNs' time could explain both the interruptions and medication error rates.

The limitations of sample size preclude definitive evidence that the CMT/As provide a safe medication delivery for routine medications. Although the findings suggest that CMT/As have the ability to provide a safe medication administration, many factors remain unaddressed. As noted earlier, nursing home residents have many illnesses, they take many medications, and they are very vulnerable to subtle alterations in their medication regimens. Many of the medications delivered in a routine medication administration do require assessment for potential adverse effects, and CMT/As lack the assessment skills and knowledge to make adjustments or watch for many potential adverse drug events.

## Conclusions

Nursing homes have many challenges in the midst of very fiscally constrained budgets to provide safe care. Innovation and evidence must be a critical part of how care is delivered to this ever-growing and very frail population. In an ideal world, the frail and vulnerable residents would have RNs providing all aspects of their care. However, in a fiscally constrained world, staff representing many levels of credentialing must be maximized to assure that care can be given. This study provides some initial evidence to suggest that CMT/As can be effectively used for routine medication administration. The study also suggests that minimizing interruptions would improve the safety of medication administration. Understanding the limitations of the CMT/A and creating medication systems that include the RN and the CMT/A as partners could provide a safe medication administration where residents get

the right medication, at the right time, in the right dose, through the right route, and prepared in the right method to assure the most therapeutic result.

## References

- Barker, K. N., Flynn, E. A., Pepper, G. A., Bates, D. W., & Mikeal, R. L. (2002). Medication errors observed in 36 health care facilities. *Archives of Internal Medicine*, *162*, 1897-1903.
- Bates, D., Cullen, D., Laird, N., Petersen, L., Small, S., Servi, R., et al. (1995). Incidence of adverse drug events and potential adverse drug events: Implications for prevention. *Journal of the American Medical Association*, *274*, 29-34.
- Deans, C. (2005). Medication errors and professional practice of registered nurses. *Collegian: Journal of the Royal College of Nursing, Australia*, *12*, 29-33.
- Gurwitz, J. H., Field, T. S., Judge, J., Rochon, P., Harrold, L. R., Cadoret, C., et al. (2005). The incidence of adverse drug events in two large academic long-term care facilities. *American Journal of Medicine*, *118*, 251-258.
- Lambert, M. J. (2004). *Leading a patient-safe organization*. Chicago: Health Administration Press.
- Pape, T. M., Guerra, D. M., Muzquiz, M., Bryant, J. B., Ingram, M., Schraner, B., et al. (2005). Innovative approaches to reducing nurses' distractions during medication administration. *Journal of Continuing Education in Nursing*, *36*, 108-116.
- Pelletier, P. L. (2001). Medications errors: A lesson from long-term care. *Nursing Management*, *32*(11), 49-50.
- Smith, J., & Crawford, L. (2003). Medication errors and difficulty in first patient assignments of newly licensed nurses. *Journal of Nursing Administration's Healthcare, Law, Ethics, & Regulation*, *5*(3), 65-67.
- Vogelsmeier, A., Scott-Cawiezell, J., & Zellmer, D. (in press). Barriers to safe medication administration in the nursing home. *Journal of Gerontological Nursing*.
- Wakefield, B. J., Wakefield, D. S., Uden-Holman, T., & Blegen, M. A. (1998). Nurses' perceptions of why medication administration errors occur. *MedSurg Nursing*, *7*(1), 39-44.

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# Practice/Regulation Partnerships:

## The Pathway to Increased Safety in Nursing Practice, Health Care Systems, and Patient Care

In its quest to create and sustain cultures of safety, the Institute of Medicine (IOM) called on the National Council of State Boards of Nursing to develop and design standardized processes to better distinguish human error from willful negligence and intentional misconduct.<sup>1</sup> Though this charge is worthy and is being implemented, boards of nursing also are benefiting from the evidence that is coming forth about human errors and Just Culture.<sup>2-4</sup> Just Culture is a method to promote cultures of safety by regulators, employers, and employees working together to create an open environment where health care risks can be openly discussed. Just Culture seeks to evaluate normal error, at-risk behavior, and reckless behavior to provide appropriate resolution of adverse events.

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This approach requires new leadership and collaborative initiatives that call on safety science, regulatory authority, and workplace redesign to create new models of patient safety and adequately address the issues surrounding the promotion of patient safety initiatives and the implementation of comprehensive methods for error resolution.

Recent research<sup>5-7</sup> and the highly publicized IOM reports have greatly changed the landscape of health care. Predominant themes and findings in these reports indicated a need to examine the causal effects of associated systems factors that contribute to medical errors. The reports suggest that focusing on both human performance and systems factors allow for a better understanding of why errors occur and contribute to the development of more robust interventions, thus increasing safety for both patient and practitioner.<sup>1,8,9</sup>

Prompted by an understanding of the importance of Just Culture<sup>3</sup> in advancing the patient safety movement, a unique partnership was developed in the state of Texas between leaders of the Board of Nurse Examiners (BNE) for the State of Texas and the Institute for Healthcare Excellence at the University of Texas M.D. Anderson Cancer Center to evaluate needed changes in the relationship between practice environments and regulatory agencies to promote a comprehensive approach to error analysis and resolution. This partnership, called the Healthcare Alliance Safety Partnership (HASP), is a BNE pilot program that allows for some exceptions to the mandatory reporting requirements for purposes of research in patient safety (see [www.texashasp.org](http://www.texashasp.org)).<sup>10,11</sup>

### HASP PROGRAM OVERVIEW

HASP is a pilot nonpunitive reporting program that adapts the airline industry's highly successful Aviation Safety Action Partnership (ASAP) to health care. Currently used by major airline carriers, ASAP consists of the review of error reports from a member of the Federal Aviation Administration, a member of the pilot union, and a member

of an airline to understand the prevalence of human performance and systems factors that contributed to the error.<sup>12</sup> The ASAP process has been successful to date because it allows participating organizations to learn about systems factors impacting aviation through reports submitted by pilots. Because ASAP has no jeopardy for the reporting pilot, reports are rich in safety information that might not be learned from traditional aviation reporting systems.

The IOM report *To Err is Human*<sup>9</sup> recommended using as many innovative safety techniques that are applicable to health care and suggested that a nonpunitive approach to error reporting would increase the understanding of unsafe conditions. Imperatives to study patient safety have escalated since the IOM reports and increased emphasis on safety from accrediting agencies.<sup>1,8,9</sup> Experts in cognitive psychology, ergonomics, and human factors have supported the examination of human error in health care. James Reason, the noted human factors scientist, discussed the importance of understanding systems factors in health care and the need to develop reporting systems that would capture such factors.<sup>6</sup> However, pragmatic application of safety science within the existing system of regulating health care has not been demonstrated.

Clearly an alliance of significant stakeholders has been needed to explore the efficacy of a nonpunitive system that meets the obligations of the regulatory duties to the consumer and informs the health care system of important safety issues and interventions, thus protecting the public. Consistent with the BNE mission<sup>13</sup> and the systems focus of recent IOM reports, HASP seeks to provide protection to the public while also documenting the role of systems and human performance factors in error occurrence.<sup>11</sup> The HASP program does not replace any existing quality improvement or assurance program at a given institution; it is an added program that falls within the protection of peer review, recognizes the effects of human and systems factors, contributes to the development of just cultures for practitioners and providers, and, ultimately, enhances the safety of patients.

Three hospitals participated in the initial HASP program: University of Texas M.D. Anderson Cancer Center, St Luke's Episcopal Hospital, and Texas Children's Hospital. Each participating institution has business agreements with HASP for confidentiality and has passed an IRB review. Each participating institution provides participants for the event review committee, allows full access to the fa-

cility and records around an event, and access to any quality or risk management information, such as root cause analysis. Each institution also agrees to provide any necessary remediation support to the nurse involved.

#### **BNE BACKGROUND**

The BNE is the state agency that regulates the licensure, education, and practice of over 278,000 professional and vocational nurses in Texas. The focus on the individual nurse's accountability in patient safety has long been the purview of regulatory boards such as the Texas BNE. However, with emerging evidence from patient safety research that multiple factors may contribute to errors in health care, the leaders at the Texas BNE began exploring a new methodology to more thoroughly evaluate reported nursing practice errors. Research studies were providing evidence that system factors, as well as the health care team, the patient, and individual nursing competency factors contributed to errors in health care.<sup>1,6,7,14-16</sup> These studies suggested that an in-depth review of all of these factors is required to thoroughly evaluate errors in health care.

Because the BNE, as a nursing regulatory agency, did not have access to detailed information about system issues within health care organizations, new models were needed to facilitate partnerships between the BNE, safety experts, and health care organizations to review systems issues that impacted nursing practice. For the BNE to explore new models of nursing regulation, the Texas Legislature needed to amend the Nursing Practice Act. Consequently, during the 78<sup>th</sup> Texas Legislature in 2003, Senate Bill 718 was

introduced and passed. It allowed the BNE to conduct pilot studies that promoted research and review of innovative methodologies in the regulation of nurses. The pilot programs allowed models that promoted practice environments where fear associated with making a health care error was decreased.<sup>17</sup> By implementing "just cultures" that did not blame or shame those who make errors, it was hypothesized that practitioners participating in reporting systems would increase, thereby promoting a better analysis and resolution of error events. The pilot programs facilitated the BNE's ability to grant some exceptions to the mandatory reporting requirements for nursing practice errors, provided the pilot study ensured an equivalent method for assuring patient safety.<sup>11</sup>

In December 2003, the BNE released a request for proposals to health care organizations that met the criteria

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outlined in the board's rules.<sup>18</sup> In April 2004, University of Texas M.D. Anderson Cancer Center proposed a pilot that was reviewed by an expert panel and ultimately received approval to implement the HASP.

### THE HASP PROGRAM

The HASP program evaluation method consists of proven techniques derived from high-risk industries. There are three phases of a HASP review: the discovery, the analysis, and the resolution. Each step is documented by the HASP team and archived under a unique tracking number. All the evidence and supporting documentation are collected into one casebook used in the review by the ERC.

#### Phase 1: Discovery

The first stage of the HASP process includes the voluntary submission of an event report from a registered nurse. The report may be obtained from one of three sources:

- Self-report from a nurse
- Referral from the nurse's institutional peer review committee
- Referral from the BNE

Each report requires the participant to file an incident report under his facility's current process to meet risk and required reporting (Texas Department State Health Services, Federal Drug Administration, etc, as appropriate). If an incident report is not submitted simultaneously with a self-report to HASP, the self-report is excluded from the program. Since the HASP process does not take the place of internal quality processes, it is mandatory that an incident report is filed to initiate the internal quality and risk processes of the institution or delay appropriate safety measures by the institution.

On receiving a report—and during the discovery phase—the report will be screened for exclusion criteria. Exclusion criteria for the HASP includes events that:

- Contributed to a patient death or serious injury
- Are intentional
- Involve an intentional disregard for safety
- Involve a knowing violation of safe operating principles
- Involve criminal activity
- Involve substance abuse including mind-altering substance or physical/medical conditions that impaired or influenced the nurse's actions
- Involve a nurse with any history of substance abuse regardless of whether the BNE knows the history and whether rehabilitation has occurred. Nurses with a past history of abuse that have completed the TPAPIN program or an alternative program at the discretion of

Since the HASP process does not take the place of internal quality processes, it is mandatory that an incident report is filed to initiate the internal quality and risk processes of the institution or delay appropriate safety measures by the institution.

the BNE may petition the BNE for a waiver of this exclusion to participate in the HASP

- Involve intentional falsification
- Are reportable under Texas occupation code 301.1606 and 22 T.A.C. 226.4(b)(c)

In addition, immediately after receipt of a report, a preliminary notification is made to the BNE to verify the nurse's license, check for past reportable conduct to the BNE, summarize the report in brief, and to alert the BNE that the report has been filed. After screening by HASP nurse analysts, the report is de-identified, receives a unique tracking number, and enters the HASP process.

After the nurse files an initial report of the event, he is interviewed with scripted questions. The resulting information guides the members of the HASP staff who review all relevant records, policies, and procedures. Interviews with directly and indirectly involved parties are conducted in the same structured interview format. Comments are recorded, with identifying information of interviewees and patients removed.

Assessments of the environment, workplace, and technology issues are performed, as well as observations of clinical practice. Medication data, specifically pharmacy and automated medication delivery service records, are searched, as necessary. Incident and root cause reports generated by the facility are reviewed and added to the evidence. The resulting information, along with other gathered evidence, is de-identified and incorporated into the ongoing creation of a Cause Map.<sup>19</sup> A preliminary issues list is begun and a case book is compiled and sent to members of the ERC approximately 1 week prior to the scheduled review meeting.

#### Phase 2: The Analysis Phase

HASP nurse analysts identify and cluster causal factors of the event using the cause map and then categorize these causal factors using a modified version of the Eindhoven Classification model,<sup>5</sup> which classifies errors based on systems and human performance factors. Consistent with this model, HASP analysts describe systems factors as technical, organizational, or patient-related, and human performance factors are classified as knowledge-based, rule-based, and skill-based behaviors.

Once an analysis is implemented, a call is made to the ERC, which consists of six people who are members of the other participating organizations. The voting members are a nursing officer, who provides an administrative perspective; a BNE member, who represents board and licensure requirements; and a chair of a peer review committee who

is familiar with the peer review process. These members are responsible for reviewing and analyzing reports submitted, determining whether submitted reports qualify for inclusion in HASP, identifying system and human performance factors, and proposing interventions for the identified factors. These three members have voting privileges, which means that after reviewing all available information about a nurse's error, the members are responsible for reaching consensus or voluntary agreement about the actions taken to protect the public. The additional three members of the ERC, who are nonvoting members, provide technical support and include a nurse analyst with system and human factors expertise, a facilitator, and an administrative assistant.

All materials are presented as anonymously as possible and confidentially at the event review committee (ERC) meeting. During the meeting, an action plan is created that includes prescriptive recommendations for the nurse and the participating institution. Timelines for completion of action items, including any interim reports, are noted as appropriate and followed up in the Resolution phase. The Just Culture algorithm<sup>2</sup> and James Reason's systems analysis tools<sup>16</sup> are applied to consider individual versus systems responsibility.

True to the theory of systems accountability, each individual and component involved in an event are considered to be accountable and part of the resolution. Therefore, each action plan addresses multiple layers of the event and offers interventions on organizational, individual, and technical factors.

### Phase 3: The Resolution

The institution and the nurse provide timely responses to the HASP analysts regarding prescriptive recommendations until resolution is complete and approved by the ERC. HASP then presents a final report to the BNE in quarterly general meetings and an annual review. A board representative is always a member of the ERC to make decisions about the action plans. Congruent with the board's mandated responsibility to the public, any needed remediation activities for the nurse to promote competency are outlined and closely monitored.

An exciting component of the pilot is that by having a partnership with the nurse's employer, new methods for promoting competency are being developed. For instance, one employer assigned a clinical nurse specialist to develop and oversee the completion of a detailed competency-based educational plan for a nurse. The specificity of the plan and the concurrent oversight and evaluation by an expert nurse in the nurse's work setting lends itself to the identification and resolution of individual competency requirements not currently available to the board.

### CONCLUSION

The HASP model offers a level of transparency that allows for a natural partnership to explore and improve the practice environment from multiple viewpoints. Significant lessons have been learned by regulators, nurse

leaders, and caregivers that are resulting in a safer environment in which to practice nursing. As a demonstration project, the process has shown considerable results. The HASP process is thorough, uses advanced investigation techniques and theories, and surpasses the usual root cause analysis. The process requires significant time, expertise, and methods to implement effectively.

The current HASP model also highlights a more urgent level of issues within nursing practice: how do we address advanced knowledge in safety, systems analysis, and human factors within a responsible professional model of nursing practice? Currently barriers exist between the practice environment and the ability of the BNE to gain systems information regarding the error event, thereby limiting an analysis of the influence of the system on the nurse's practice. Traditional concerns regarding legal and regulatory compliance, attribution of events solely to the individual, and tension between industry and regulation have prevented full discovery of these issues.

The need for a program that documents adverse medical errors and addresses human performance *and* systems factors is critical, especially in an industry that acknowledges 98,000 deaths per year. Unfortunately, although human factors science has been cited in all of the IOM reports as essential to creating a safer health care system, current working knowledge of human factors in the industry is limited. Since workplace redesign is essential to creating a safer practice environment and depends on an in-depth analysis of the systems influencing nursing practice, pilot programs that incorporate such knowledge are essential to moving safety forward. The current program, HASP, has been developed to answer this critical call.

### References

1. Page A, Institute of Medicine, ed. Keeping patients safe: transforming the work environment of nurses. Washington DC: The National Academies Press; 2004.
2. Outcome Engineering. The Just Culture community. Available: <http://www.justculture.org/>. Accessed February 19, 2007.
3. Marx D. Patient safety and the "just culture": a primer for health care executives. New York: Columbia University; 2001.
4. The Just Culture Community. In recognition of a growing community. Available: <http://www.justculture.org>. Accessed April 3, 2007.
5. van der Schaaf TW. Developing and using cognitive task typologies. *Ergonomics*. 1993;36(11):1439-44.
6. Reason J. Human Error. Cambridge, MA: Cambridge University Press; 1990.
7. Helmreich RL. On error management: lessons from aviation. *Br Med J*. 2000;320(7237):781-85.
8. Kohn LT, Corrigan J, Donaldson MS, Institute of Medicine, ed. Crossing the quality chasm: a new health system for the 21st century. Washington DC: The National Academies Press; 2001.
9. Corrigan J, Cohen LT, Davidson MS, Institute of Medicine, eds. To err is human: building a safer health system. 1st ed. Washington DC: The National Academies Press; 2000.
10. The Healthcare Alliance Safety Partnership. Available: [www.TexasHASP.org](http://www.TexasHASP.org). Accessed February 19, 2007.
11. Texas Board of Nurse Examiners. Board adopts new 22 TAC § 226 concerning Patient Safety Pilot Programs on Nurse Reporting Systems and develops application for proposal of Patient Safety Pilot Program. Available: <http://www.bne.state.tx.us/about/news123103.html>. Accessed February 19, 2007.

12. U.S. Department of Transportation, Federal Aviation Administration. Aviation safety action program. Available: [http://www.faa.gov/safety/programs\\_initiatives/aircraft\\_aviation/asap/](http://www.faa.gov/safety/programs_initiatives/aircraft_aviation/asap/). Accessed February 20, 2007.
13. Texas Board of Nurse Examiners. Compact with Texans. 2007. Available: <http://www.bne.state.tx.us/compact.html>. Accessed February 20, 2007.
14. Benner P, Sheets V, Uris P, Malloch K, Schwed K, Jamison D. Individual, practice, and system causes of errors in nursing: a taxonomy. *J Nurs Admin*. 2002;32(10):509-23.
15. Green A, Wieck KL, Willmann J, Fowler C, Douglas W, Jordan C. Addressing the Texas nursing shortage: A legislative approach to bolstering the nursing education pipeline. *Policy Politics Nursing Practice*. 2004;5(1):41-8.
16. Reason JT. Managing the risks of organizational accidents. Burlington, VT: Ashgate Publishing Company; 1997.
17. Senate Research Center. Highlights of the 78th Texas legislature regular session: A summary of the most significant legislation. July 2003. Available: <http://www.senate.state.tx.us/src/pdf/78thHighlights.pdf>. Accessed February 20, 2007.
18. Texas Board of Nurse Examiners. Request for proposal for board of nurse examiner's patient safety pilot program. Accessed February 20, 2007.
19. ThinkReliability. The cause mapping process. Available: <http://www.thinkreliability.com/causemapping.htm>. Accessed February 19, 2007.

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## The White Paper

Continued from page 29

units to the board of directors. The unit white paper offers a realistic and comprehensive overview of the unit, the team, and the outcomes and the support provided to improve areas of concern. This brief, content-rich document also is a reminder to current staff of their accomplishments and quality health care services.

### CONCLUSION

Most individuals want to paint a rosy picture of their facility, unit, or team. The challenge is to create an accurate picture that is neither overly positive nor unnecessarily negative. The goal is to recognize both accomplishments and opportunities for improvement and the strategies to improve outcomes. An excellent white paper can be researched and written in around 6-8 hours, but the time frame depends on the availability of the key information, the skill level of the writer, and the complexity of the unit. Some information will be static—the number of beds a hospital is licensed for or the square footage of a patient room, for instance. Some information will be dynamic, such as vacancy rates and employee turnover. The more changes that have occurred over the past year, the longer the white paper update will take. Unless there have been a lot of changes on your unit during the past year, updating can be done in about 1 hour.

### Reference

1. Porter-O'Grady T, Malloch K. Managing for success in health care. St. Louis: Elsevier; 2007.

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**Initial licensure:**

- 1) For any criminal offense, including those pending appeal, have you:
  - A. been convicted of a misdemeanor?
  - B. been convicted of a felony?
  - C. pled nolo contendere, no contest, or guilty?
  - D. received deferred adjudication?
  - E. been placed on community supervision or court-ordered probation, whether or not adjudicated guilty?
  - F. been sentenced to serve jail or prison time? court-ordered confinement?
  - G. been granted pre-trial diversion?
  - H. been arrested or any pending criminal charges?
  - I. been cited or charged with any violation of the law?

(You may only exclude Class C misdemeanor traffic violations.)

If you answered "YES" to the aforementioned questions, attach a separate explanation for each arrest, charge, citation, or ticket. In addition, provide legible copies of all court records and arrest/offense/incident reports, or citation/tickets. If a court or an arresting/ticketing agency is unable to provide copies of applicable records, obtain a written statement so stating from the court or agency.

**NOTE: Expunged and Sealed Offenses:** While expunged or sealed offenses, arrests, tickets, or citations need not be disclosed, it is your responsibility to ensure the offense, arrest, ticket or citation has, in fact, been expunged or sealed. It is recommended that you obtain a copy of the Court Order expunging or sealing the record in question. Failure to reveal an offense, arrest, ticket, or citation that is not in fact expunged or sealed, at a minimum, may subject your license to a disciplinary fine and raises questions related to truthfulness in addition to questions regarding the offense itself.

**NOTE: Orders of Non-Disclosure:** Pursuant to Tex. Gov't Code § 552.142(b), if you have criminal matters that are the subject of an order of non-disclosure you are not required to reveal those criminal matters on this form. However, a criminal matter that is the subject of an order of non-disclosure may become a character and fitness issue. Pursuant to other sections of the Gov't Code chapter 411, the Texas Board of Nurse Examiners is entitled to access criminal history record information that is the subject of an order of non-disclosure. If the Board discovers a criminal matter that is the subject of an order of non-disclosure, even if you properly did not reveal that matter, the Board may ask you to provide information about that criminal matter.

- 2) Are you currently the target or subject of a grand jury or governmental agency investigation?

**Renewals:**

- 1) Have you, within the past 24 months or since your last renewal, for any criminal offense, including those pending appeal:
  - A. been convicted of a misdemeanor?
  - B. been convicted of a felony?
  - C. pled nolo contendere, no contest, or guilty?
  - D. received deferred adjudication?
  - E. been placed on community supervision or court-ordered probation, whether or not adjudicated guilty?
  - F. been sentenced to serve jail or prison time?
  - G. been granted pre-trial diversion?
  - H. been arrested or any pending criminal charges?
  - I. been cited or charged with any violation of the law?

(You may only exclude Class C misdemeanor traffic violations or offenses previously disclosed to the Texas Board of Nurse Examiners on an initial or renewal licensure application.)

If you answered "YES" to the aforementioned questions, attach a separate explanation for each arrest, charge, citation, or ticket. In addition, provide legible copies of all court records and arrest/offense/incident reports, or citation/tickets. If a court or an arresting/ticketing agency is unable to provide copies of applicable records, obtain a written statement so stating from the court or agency.

**NOTE: Expunged and Sealed Offenses:** While expunged or sealed offenses, arrests, tickets, or citations need not be disclosed, it is your responsibility to ensure the offense, arrest, ticket or citation has, in fact, been expunged or sealed. It is recommended that you obtain a copy of the Court Order expunging or sealing the record in question. Failure to reveal an offense, arrest, ticket, or citation that is not in fact expunged or sealed may, at a minimum, subject your license to a disciplinary fine and raises questions related to truthfulness in addition to questions regarding the offense itself.

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- 2) Are you currently the target or subject of a grand jury or governmental agency investigation?
- 3) Has any licensing authority refused to issue you a license or ever revoked, annulled, cancelled, accepted surrender of, suspended, placed on probation, refused to renew a nursing license, certificate, or multi-state privilege held by you now or previously, or ever fined, censured, reprimanded, or otherwise disciplined you? (You may exclude disciplinary actions previously disclosed to the Texas Board of Nurse Examiners on an initial or renewal licensure application.)