Complaint Evaluation Tool

Reporting

- Fear and confusion. What to report? What if I don’t report?
- How does reporting an issue to the Board coincide with organizational reporting?
- Do we need to report everything? If not, what is the threshold?
- The practice act is confusing. I’ll just report everything.
- I don’t understand why I was reported, everyone does it.

When to report???

- Mandatory reporting: required
- OAR 851-045-0090
  - Not intended that every and every nursing error be reported.
  - Anyone knowing of a nurse whose behavior or nursing practice fails to meet accepted standards for the level at which the nurse is licensed shall report the nurse to the person at the work setting who has authority to institute corrective action. *Anyone who has knowledge or concern that the nurse's behavior or practice presents a potential for or actual danger to the public health, safety and welfare*, shall report or cause a report to be made to the Board of Nursing. Failure of any licensed nurse to comply with this reporting requirement may in itself constitute a violation of nursing standards.

The Following ***MUST*** Always Be Reported to the Board:

- Practicing nursing when the license becomes void due to nonpayment of fees.
- Dismissal from employment due to unsafe practice or conduct derogatory to the standards of nursing. "Dismissal" vs "Resignation in Lieu of Termination".
- Client Abuse or Neglect.
- Practicing Nursing when physically or mentally ability to practice is impaired.
- Arrest for a felony crime, to be reported to the Board within 10 days of the arrest.
- Conviction of a misdemeanor for felony crime which shall be reported within 10 days of the conviction.
- ***Failure to report in itself is a violation of the practice act.***
- What about Diversion of Medication?

Would the Board accept the outcome from a decision-making tool?

- Supported by OAR 851-045-0090 (5):
- The decision to report a suspected violation of ORS Chapter 678 or the rules adopted within, shall be based on, but not limited to, the following:
  - (a) The past history of the licensee's performance
  - (b) A demonstrated pattern of substandard practice, errors in practice or conduct derogatory to the standards of nursing, despite efforts to assist the licensee to improve practice or conduct through a plan of correction; and
  - (c) The magnitude of any single occurrence for actual or potential harm to the public health, safety and welfare.

The North Carolina Board of Nursing: Complaint Evaluation Tool

- Proposed to adopt for Oregon as a guide for when reporting to the Board may or may not be necessary.
- Does not prohibit reporting for those who want to report.
- Adopted as an Interpretive Statement, not as an absolute.
- Approved by the Board in Sept 2016

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OREGON STATE BOARD OF NURSING (OSBN): COMPLAINT EVALUATION TOOL

This form has been adapted, with permission, from the North Carolina Board of Nursing CET Tool. The OSBN wishes to thank the Board and staff of the North Carolina Board of Nursing for their consent to adapt this form for use in Oregon.

This form is to be used when there is a question if an incident involving nursing practice should be reported to the OSBN. It is not the intent of the Board that each and every nursing error be reported (OAR 851-045-0090 (1). This document is intended to be used to determine if an incident should be reported. If the decision is to NOT report, this form should be maintained by the individual completing the form in a manner consistent with organizational policy. If the decision is to report, please include this form with the complaint. Note that the use of this form is not required to determine if a report should be made. Any error may be reported if the reporter feels it is in the interest of public safety to do so.

Instructions:

1. This is a non-fillable PDF form; please print and complete.
2. Rate the practice event in all five horizontal rows.

   G General Nursing Practice
   U Understanding/level of experience
   I Internal policies/standards/LIP orders
   D Decision/choice
   E Ethics/credibility/accountability

3. Determine the numerical value of the criteria in the vertical columns that best describe the event, and then place that number in the far-right hand column. Note the vertical columns indicate Human Error (Green), At Risk Behavior (Yellow) and Reckless Behavior (Red).

Human Error	At Risk Behavior			Reckless Behavior	
0	1	2	3	4	5

Total the Criteria score at the bottom of the page and transfer to the second page in the section marked “Criteria Score from Page 1”.

4. Select and total number of applicable mitigating and aggravating factors. Mitigating and Aggravating Factors may influence the final decision regarding reportability.
5. Based on the total criteria score and number of color categories, follow the recommendations in each box.
6. If this form is used to make the decision to report, please include it in your complaint.
7. Board staff is available to assist if you need help completing this form: Please call the Nursing Practice Consultant group at 971-673-0685 and select the “Policy Analyst” option.

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OREGON STATE BOARD OF NURSING (OSBN): COMPLAINT EVALUATION TOOL

Allegation (s): ______________________ Licensee's Name: ______________________

	Criteria	Human Error	At Risk Behavior			Reckless Behavior		Score
		0	1	2	3	4	5	
G	General Nursing Practice	No prior written counseling for practice issues	Prior written counseling for single non-related practice issue within the last 12 months.	Prior written counseling for single related practice issue within the past 12 months	Prior written counseling for various practice issues within the past 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.	
U	Understanding/ Level of Experience	Has knowledge, skills and ability. Incident was accidental, inadvertent, or oversight.	Limited understanding of correct procedure. May be novice <6 months of experience in nursing or with the current event/activity.	Limited understanding of options/resources. Aware of correct procedure but in this instance cut 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.	
I	Internal Policies/standards and/or LIP orders for care	Unintentional breach or no policy/standard/LIP order exists.	Policy/Standard/LIP order has not been enforced as evidenced by cultural norm (common deviation of staff) or policy/standard/LIP order was misinterpreted.	Policy/Standard/LIP 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/LIP 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/LIP order for own personal gain.	Intentional disregard of policy/standard/order with understanding of negative consequences for the client.	
D	Decision/Choice	Accidental/mistake/ inadvertent error	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 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 egregious/flagrant choice, Put own interest above that of the client/agency/public. Intentionally neglected red flags. Substantial and unjustifiable risk.	
E	Ethics/credibility/ accountability	Identified own error and self-reported. Honest and remorseful.	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.	Total

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OREGON STATE BOARD OF NURSING (OSBN): COMPLAINT EVALUATION TOOL

Page 2: Complaint Evaluation Tool: Mitigating and Aggravating Circumstances

Definitions:

Mitigating Factor: Does not excuse or justify conduct but factors considered out of fairness in deciding the degree of the offense.

Aggravating Factor: Factors that increase the severity or culpability of the offense.

These factors do not contribute to the score decision making; however, they will describe factors to be reviewed should a report be made to the Board.

	Mitigating Factors – check all that apply		Aggravating Factors – check all that apply
	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 /60 hours in a work week 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 work week 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)		
	Total # of mitigating factors identified		Total # aggravating factors identified

Criteria Score from Page 1 ______________

No Board Report Required	Report or call the Board for Consultation if Unsure	**Board Report Required (Mandatory)**
3 or more criteria in Green OR Criteria score of 6 or less	3 or more criteria in Yellow OR Criteria score 7-15	**2 or more criteria in Red** OR Criteria score 16 or more OR Incident involved fraud, client abuse, theft, diversion, sexual misconduct, mental/physical impairment, impairment due to substance use or any mandatory reporting criteria listed in OAR 851-045-0090 (6)

Complaint Evaluation Tool Completed by ____________________ Facility Name ____________________

Contact number and email address ____________________

If OSBN contacted prior to reporting list name of staff member consulted ____________________

Recommended action by OSBN staff member ____________________

If a report is made to the Board, please fax/submit a copy of this form to the Board. If no report is made, retain in employee file per facility HR policy. This document may be subpoenaed if the Board receives a complaint against this licensee from another source.

11.00 x 8.50 in

Practice Scenario #1

Tom is your night shift charge nurse. He has been in your ICU unit for about 10 years. One of your go-to people with success as a preceptor for both students and new employees. He is the informal leader of the night shift.

He is a great educator of his peers and is well liked with both providers and staff. 4 months ago, you did have to counsel him about some of his interactions with other staff with his humor and cajoling which he interpreted as camaraderie, but a small number of staff took offense at his attempts at humor. There are no other disciplines or counseling's in his file.

You have now received a screen shot of a post that Tom placed on the unit's Facebook page. It is a picture of a particularly horrific wound on the extremity of a patient who was a hit and run victim. The caption reads:

"We do not get injuries like this very often, this patient is in bed 12, go see it before this arm is amputated because it is a goner".

When confronted Tom initially denies this has occurred and that there must be some mistake, but once you show him your screen shot of the posting he admits that he did post the picture and the caption. He then says that while he realizes that this posting may be against the hospitals confidentiality policy, there needs to be exemptions for staff education. In order to educate the staff in the care of patents like this in the future, sometimes individual patient privacy needs to be compromised.

Practice Scenario #2

Ann is an exceptional nurse. The kind of nurse that allows managers to feel confident that the patient, no matter how sick or complicated will get the care they need.
There is no record of any counseling or disciplines. A great preceptor for students and new staff.

Ann receives orders to administer a medication to a patient which requires a double check based on hospital policy. She finds another RN and together they sign off the medication based upon the policy. She administers the medication. Within 1 minute the patient starts to seize and then has a cardiac arrest. A code is called but all attempts to resuscitate the patient fails and the patient is pronounced after about a half hour of continuous efforts. While completing the charting Ann has a bit of doubt coming back to her. She retrieved the syringe that contained the original medication and to her horror she finds that the does she gave the patient is actually 10X the prescribed dose. The vial is clearly labeled as such. She immediately presents this information to the healthcare team who verify that the patient could indeed have dies from this type of overdose. Ann completes a report to the hospital. At Ann's request you hold a staff meeting where Ann discusses her error with the rest of the staff stressing to them how she made this error and that this could happen to any one of them and to exercise extra caution with these high risk medications. Ann then asks to join the nurse/pharmacy committee.

Where to find out more information about the Complaint Evaluation Tool

- Website: www.osbn.gov/osbn
- Scroll over to “resources”.
- Click on “Practice Statements and FAQ’s”
- Click on “General Policies and Information”
- Click on second item “Complaint Evaluation Tool (When do I report a nurse/Nursing Assistant)”
- Another resource: Ask for a Board Presentation

The Practice Act, Employment, and the Collective Bargaining Agreement

Comparison

Situation	Practice Act	Employment	Collective Bargaining Agreement (CBA)
License	Agreement that the licensee will abide by the practice act and is subject to the rules of the Board	None	None
Employment	none	Contract between individual and the employer to provide services in exchange for salary, benefits, etc.	A collective bargaining agreement (CBA) is a written legal contract between an employer and a union representing the employees.
Rules of Performance and Behavior	ORS 678 OAR 851 Legislative Control and	Policies and Procedures regarding what is expected from the	The CBA is the result of an extensive negotiation process between the parties regarding topics

Comparison

Situation	Practice Act	Employment	Collective Bargaining Agreement (CBA)
Consequence for Violation	If reported or becomes known to the Board, investigation and possible sanctions against the license.	Depending on severity discipline, termination, resignation. Based upon terms of CBA	Possible legal action by either bargaining unit or employer against each other; condition of bargaining
Criminal Prosecution	Against license, not the individual. However, discipline is public record, law enforcement may take action separate and apart from the Board. Depending upon concern, Board staff may need to report to law enforcement.	Prerogative of the employer	Not specifically for the agreement.

Comparison

Situation	Practice Act	Employment	Collective Bargaining Agreement (CBA)
Staffing Law	No state authority over staffing law may be related to reported unsafe care issues.	If defined by law as a covered entity, required to follow staffing laws.	Additional staffing requirements may be bargained by not considered a law.
Accountability for Compliance	The individual is accountable to the license	Employer and Employee	Employer and Bargaining Unit
Tier Status	The Law, supersedes both employment and the CBA. Applicable to all who have a license and use that license to seek employment or label themselves as such a license holder. Can be binding 24/7	Condition of employment. Relationship terminated upon separation from employment. Depending on role within the organization may be held accountable for behavior off hours.	Binds the employer and the bargaining unit in a lawful agreement as long the bargaining unit is recognized by the employees.