Patient Safety Culture and Barriers to Adverse Event Reporting: A National Survey of Nurse Executives

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Introduction: Although boards of nursing (BONs) ensure nurse competency and fitness to practice through the regulatory process, it is nurse executives who enforce the Nurse Practice Act and standards of care in the clinical setting. As such, it is a nurse executive's responsibility to uphold the culture of safety. **Aims:** To better understand nursing executives' current protocols for reporting serious adverse events to state BONs and to identify potential reporting barriers. **Methods:** A national survey was administered to members of the American Organization of Nurse Executives and the National Association of Directors of Nursing Administration in January 2018. The study collected demographic and professional data, as well as health facility information and practice related to serious adverse event reporting. Analysis included a descriptive summary and univariable and multivariable ordinal logistic regression models to examine drivers of and barriers to serious adverse event reporting. **Results:** A total of 441 participants completed the survey. Respondents included directors of nursing (35.6%), chief nursing officers (21.5%), chief nursing executives (17.2%), and nurse managers (9.1%). There was broad coverage across U.S. Census regions: South (33.9%), Midwest (30.8%), Northeast (19.1%), and West (16.2%). Executives who are aware of state BON guidelines (OR = 2.52, 95% CI: 1.56 – 4.09, p <.001), have a policy in place (OR = 1.73, 95% CI: 1.10 – 2.72, p = .02), and express satisfaction with said policy (OR = 1.39, 95% CI: 1.11 – 1.74, p = .004) are significantly more likely to report a violation of the Nurse Practice Act to their state BON. Difficulty knowing what is reportable (OR = 0.30, 95% CI: 0.19 – 0.49, p <.001), how to file a report (OR = 0.39, 95% CI: 0.22 – 0.69, p <.001), concern over legal ramifications (OR = 0.48, 95% CI: 0.28 – 0.84, p = .01), and facility culture (OR = 0.26, 95% CI: 0.13 – 0.52, p < .001) are significant barriers to BON reporting. **Conclusion:** Nurse executives encounter barriers to BON reporting. Additional resources to align facility practice related to nurse discipline are needed. Ongoing BON education and outreach will help facilitate serious adverse event reporting, which can enhance patient safety.

Keywords: Adverse event reporting, boards of nursing, nurse executive, nursing regulation, patient safety

Both nurse regulators and nurse executives prioritize public protection. While boards of nursing (BONs) ensure the competency and fitness to practice of nurses through the regulatory process, nurse executives enforce the Nurse Practice Act (NPA) and standards of care in the clinical setting (Hudspeth, 2014; Tanga, 2011). As such, it is the responsibility of a nurse executive to uphold the culture of safety in each health care facility (The Joint Commission, 2009). With these common goals in mind, the National Council of State Boards of Nursing (NCSBN) sought to explore the relationship and interaction between nurse executives and BONs related to serious adverse event tracking, reporting, and discipline.

Background

Chief nursing officers (CNOs) are tasked with making decisions that inevitably involve broader regulatory implications. Therefore, it is imperative that nurses serving in these leadership roles develop an understanding of the complexities of regulation and forge a working relationship with their state BONs (Hudson, 2008). These tasks become critically important in the patient safety context, particularly in the tracking and reporting of adverse events. The National Patient Safety Foundation (2015) defines an adverse event as an untoward incident, therapeutic misadventure, iatrogenic injury, or other occurrence of harm or potential harm directly associated with care or services provided. In the nursing context, an unsafe action resulting in such harm may be further classified as human error (an inadvertent slip), at-risk behavior (a drift toward unsafe habits; potentially negligence for a justifiable reason), or reckless behavior (intentional disregard for safety or taking an unjustifiable risk) (Harris, Burhans, Edwards, & Sullivan, 2013).

The NPA delegates authority to state BONs to ensure nurse competence and implement disciplinary processes for practice-related violations (Russell, 2012). However, disciplinary action for unintended errors may serve as a disincentive for staff to self-report

or report the actions of colleagues (Cooper et al., 2016). Recent findings from the 2018 *Hospital Survey on Patient Safety Culture* also identify systemic issues contributing to mistakes outside of the nurse's control, such as understaffing (Famolaro et al., 2018). Thus, in determining the appropriate response to an adverse event, many employers seek to establish a "just culture," which considers both systems issues and individual behavioral choices as contributing factors (Boysen, 2013; Page, 2007). Just culture environments focus on education rather than punishment when error is involved, but they do not exclude holding individuals accountable in the case of negligence or true disregard for risk (Frankel, Leonard, & Denham, 2006; Harris et al, 2013; Marx, 2001). Evidence shows that such models function best by developing a highly understandable framework that can be replicated and implemented facility wide (Berwick, 2003).

In the instance of a serious adverse event that includes negligence or recklessness, nurse executives have several recourses, including the termination of a nurse's employment or the acceptance of a resignation in lieu of termination. However, the nurse executive also has a responsibility, extending beyond the facility, to take steps to prevent future adverse actions by the nurse in question. Although terminating an individual's employment may address the immediate error, the root cause likely will remain (Baker & Charney, 2012; Erickson, 2012). Consequently, nurse executives' actions to prevent further harm have broader ramifications that reverberate across the professional and regulatory landscape. To facilitate this charge, the state BONs partner with local facilities to better articulate the process for filing complaints against nurses, as well as the ensuing investigative process (Saver, 2010). In many states, nurse executives are also required by law to report terminations or resignations related to serious adverse events to the BON. These mandatory reporting rules are an important notification mechanism for BONs, allowing regulators to maintain general oversight over a nurse's competence and conduct.

Even with mandatory reporting statutes in most U.S. jurisdictions, the literature suggests nurse executives may not always report violations to the BON (Budden, 2011; Hudspeth, 2008). As such, any record of the event may not reach the nurse's next employment setting, potentially facilitating the continuance of unsafe practice (Dahn, Alexander, Malloch, & Morgan, 2014; Hudspeth, 2008; Zhong & Thomas, 2009). Reasons for not reporting nurses who have been terminated or who have resigned in lieu of termination are not well documented but may include a lack of understanding of what regulations or statutes require reporting, uncertainty about whose responsibility it is to report, or a lack of guidance about how and what to report to the BON (Hudspeth, 2014; Ismail & Clarke, 2014; The Joint Commission, 2009). Addressing these issues requires greater communication and collaboration between nursing leadership at health care facilities and BONs (Burhans, Chastain, & George, 2012; Gorzeman, 2008; Ismail & Clarke, 2016; Ring & Fairchild, 2013).

Methods

In 2014, NCSBN and the American Organization of Nurse Executives (AONE) held a "Day of Dialogue." AONE members requested the meeting and expressed an interest in more knowledge and direction about how and when to report a nurse to the state BON. The discussion touched upon the various barriers nurse executives may face when one of their nursing staff is involved in an adverse event. To address potential issues that inhibit nurse executives from reporting a nurse's actions to the BON, NCSBN engaged in a systematic assessment of obstacles AONE members face when reporting adverse events.

To this end, NCSBN conducted a study to investigate the frequency with which nurse executives report a nurse's role in a serious adverse event to the state BON and their rationale. The investigators also sought further insight into information or resources that would assist nurse executives in determining when a report to the BON is warranted.

Study Design

An anonymous online survey was administered to all active members of AONE and the National Association of Directors of Nursing Administration (NADONA) using Qualtrics (Provo, UT). The survey consisted of 27 questions divided into three topic areas: (a) professional information (title, credentials, years in position), (b) health facility information (i.e., size, location, number of beds), and (c) health facility practices with respect to adverse event tracking and reporting. The survey was piloted with six nurse executives to ensure comprehension and sufficient scope.

Sample

NCSBN worked with representatives of AONE and NADONA to send an introductory email to nurse executives requesting their participation. Included was a web link to the survey. This email was sent to 11,916 eligible participants in January 2018 via each organization's monthly eblast. Of the eligible participants, an estimated 2,275 executives opened the communication. Individuals were given 6 weeks to complete the survey, with a participation reminder sent approximately 3 weeks after the initial email. In total, 441 of the nurse executives who opened the invitation completed the survey, for a final response rate of 19.4%. The study was reviewed and determined to be exempt by the Western Institutional Review Board.

Statistical Analysis

All but one question on the survey were fixed-response items. A thematic framework for responses to the free-text question was developed and redundant coding procedures were implemented. For this process, two independent coders evaluated and classified respondents' qualitative responses. Broader thematic categories were informed by the objectives of the study and common issues raised by respondents (Pope, Ziebland, & Mays, 2000). When disagreements arose, researchers worked to reach consensus. If dis-

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