Texas Board of Nursing Collecting Information to Better Understand Nursing Errors

This article is the first in a series that will outline the Texas Board of Nursing's (BON) participation in a national study to better understand nursing errors that are also known as nursing practice breakdown.

Boards of nursing possess considerable information that can be used to identify sources of nursing error and thus are well positioned to add to the body of knowledge surrounding errors in health care. Given that nurses comprise the largest group of health care providers and have the most interaction with patients, there is much to learn from understanding factors that lead to a breakdown in a nurse's practice. Identifying, analyzing and tracking practice breakdowns reported to boards of nursing promotes the investigation of generic patterns in error, risk factors, and system contributions. To this end, the National Council of State Boards of Nursing (NCSBN) has implemented a research study to begin to develop new approaches to identify nursing practice breakdown. Using an electronic database called the Taxonomy of Error, Root Cause Analysis of Practice-responsibility – TERCAP®, important information is collected to describe and distinguish types and sources of nursing errors.

The Texas BON has participated in the development of the TERCAP® project since July 2004. In February 2007, the online TERCAP® database became active and Texas became one of the first states to provide information about nursing practice errors reported to the Texas Board of Nursing. An updated version of TERCAP® was implemented in March 2008, to better define the items in the instrument, and since that time Texas has collected comprehensive information to further this national study.

The "heart" of the TERCAP® is composed of a taxonomy or set of categories that are based on notions of good nursing practice. These include:

Safe Medication Administration: The nurse administers the right dose of the right medication via the right route to the right patient at the right time for the right reason.

Documentation: The nurse ensures complete, accurate and timely documentation.

Attentiveness/Surveillance: The nurse monitors what is happening with the patient and staff. The nurse observes the patient's clinical condition; if the nurse has not observed the patient, then s/he cannot identify changes if they occurred and/or make knowledgeable discernments and decisions about the patient.

Clinical Reasoning: Nurses interpret patient signs, symptoms and responses to therapies. Nurses evaluate the relevance of changes in patient signs and symptoms and ensure that patient care providers are notified and that patient care is adjusted appropriately. Nurses titrate drugs and other therapies according to their assessment of patient responses.

Prevention: The nurse follows usual and customary measures to prevent risks, errors, threats to patient safety and hazards or complications due to illness or hospitalization. Hazards of immobility include skin breakdown, contractures, etc.

Intervention: The nurse properly executes healthcare procedures aimed at specific therapeutic goals. Interventions are implemented in a timely manner. Nurses perform the right intervention on the right patient.

Interpretation of Authorized Provider's Orders: The nurse interprets authorized provider orders.

Professional Responsibility / Patient Advocacy: Advocacy refers to the expectations that a nurse acts responsibly in protecting patient / family vulnerabilities and in advocating to see that patient needs / concerns are addressed. The nurse demonstrates professional responsibility and understands the nature of the nurse-patient relationship.

Why use the TERCAP® data collection instrument?
- Provides consistent and comprehensive data collection about nurses reported to the Board of Nursing in Texas, and other boards of nursing across the country
- Tracks elements of practice breakdown and recurring themes
- Assists in learning from the experiences of nurses who have had nursing practice errors
- Helps identify the characteristics of nurses at risk

What might we learn?
- How errors are identified
- When and where errors occur
- Factors in the system that affect errors
- Ways to develop and evaluate new approaches to patient safety