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PATIENT SAFETY INITIATIVE
CREATING A CULTURE OF SAFETY AND ACCOUNTABILITY

A JOINT COLLABORATION
THE OHIO BOARD OF NURSING AND NURSING EMPLOYERS

By implementing a more comprehensive approach to practice complaints, the Board believes it will directly address and impact patient safety. The goal is to increase patient safety through effective reporting, remediation, modification of systems, and accountability. The objectives are to:

- Increase employer reporting of information related to practice breakdowns
- Increase employer-sponsored practice remediation
- Incorporate Just Culture for the review of practice complaints
- Create a statewide patient safety database
- Assist with the development of a national patient safety database
- Increase the use of the Practice Intervention and Improvement Program, an alternative to discipline program of the Board

Considering these objectives, the Board agreed upon a Patient Safety Initiative to be conducted with several acute care facilities as a new approach for practice complaints. If successful, the Patient Safety Initiative will be expanded.

The Initiative includes three components:

1. The Practice Intervention and Improvement Program, known as PIIP, is the Board's confidential alternative to discipline program for eligible licensees. The program establishes a structured remedial education and monitoring program to document that the participant's practice deficiency has been corrected.

2. TERCAP (Taxonomy of Error, Root Cause Analysis and Practice-Responsibility) is a tool used to gather data and track cases involving practice breakdown. TERCAP is an initiative of the National Council of State Boards of Nursing to develop a national database on practice breakdown, and to identify patterns of error, risk factors, and system issues that contribute to practice breakdown. This will assist in the development of new approaches for patient safety.

3. Just Culture, a risk management model pioneered by Outcomes Engineering, Inc., is a systematic method that can be used by nursing employers and the Board to increase patient safety by recognizing and modifying system flaws, and by holding individuals accountable for reckless behavior or repeated behavior that poses increased risk to patients. Just Culture finds middle ground between a punitive culture that generally does not consider the systems issues that contribute to errors, and a blame-free culture, that does not hold individuals appropriately accountable. Just Culture holds individuals accountable for their performance based on their job responsibilities, but does not expect individuals to assume accountability for system flaws over which they had no control.