ur board of nursing is committed to public protection - protecting the health and well being of the public by regulating safe and effective nursing care. Historically, regulators intervene after the fact. We have to change that mindset. Public protection can be a proactive function of your board. If you think in terms of public health versus primary care, you are really trying to focus on how we can address things before they become an issue and come to the board.

In North Carolina, we license almost 130,000 nurses. We have a registry for nurse aides, too, and we have more than 2,000 nurse practitioners that we credential. We are very active with our community college system and regulate 100 programs that lead to basic licensure in nursing. Traditional functions include issuing licenses, reinstating and renewing licenses, approving programs, interpreting the law and rules related to scope of practice, investigating complaints and taking action when action is needed. Our board has 14 members who work with RNs, LPNs and public members. Our nurses actually elect the nurse members, which is very unusual. Three other public members are appointed.

Our strategic initiative is public safety and trying to be a quality regulation board, while at the same time supporting our licensees. We protect the public, but we don’t protect the professional license. We support good practice and hopefully protect the public by assuring them an adequate supply of competent licensed individuals. We are beginning to get into evidence-based practice, basing decisions on research, becoming more proactive and facilitating change and increasing collaboration.

Moving from Discipline to Practice Remediation
To begin a practice remediation program, you must be able to reach outside your normal boardroom or investigator’s office. Physicians have had some well-designed resources for assessment and remediation and, quite frankly, nurses have not had those resources. We have been fortunate in North Carolina to have some hospital systems that were willing to partner in pilot programs and try something new. The focus has been on quality improvement, basing how we look at what happened and the choices involved, as opposed to the outcome. That’s sometimes very difficult for both the employer and the regulator when someone expects retribution for a bad outcome. But quality improvement must be the focus. This is not going soft on discipline, but rather taking a proactive approach.

CAC Offers Templates for a Patient Safety Program for Regulators
In 2002, when the Citizen Advocacy Center in Washington...
ton invited us to a meeting with boards of nursing and medicine, it was funded by the Health Resources and Services Administration (HRSA). The Center offered some templates for a patient safety program and looked at impacting patient’s safety as regulators. The issue of trust was also a topic. How can we establish trust so that we will know if there are systems issues involved?

Pilot Program Begins
As a pilot program, we started with eight hospitals in North Carolina. It was very helpful to start small with agencies or employers with whom we could develop rapport. I worked in practice doing consultation, so I knew most of the hospital systems in North Carolina and had a sense of who might be open to the project. If this had been a research project, it would have been terribly biased because we began with low-hanging fruit.

Eventually, we moved from hospitals to long-term care. It was a little more challenging as there are often fewer resources and high staff turnover, especially in administration. When the state comes in and inspects or does an audit, the immediate reaction is to terminate a person or change management if something is wrong. It was still on a small scale, though. It took us until 2004 to go statewide with this program. Since then, we average 50 nurses a year that we put into Prep 4 Safety (Prep), based on direct reports from employers as well as complaints. Greater than 95% successfully complete the course.

Shifting the Focus from Blame to Understanding the Cause
We wanted to shift the focus from blaming the individual to determining what caused the negative outcome - whether it was a systems or knowledge issue, whether it was a new graduate or someone returning to work – what was the cause. To do that, we needed to develop a relationship of open communications and trust with the participating organizations. Most incidents are reported by nurses in administrative positions; they are generally willing to share information with the board of nursing, but I think it’s also very important for that trust piece to be there. (I would add that agencies prefer that you have just one identified person who coordinates the program.)

Prep 4 Safety as an Early Intervention
Can early invention really make a difference, improve competency and safe practice? That is very difficult to measure without a lot of hard research, and we do not have that luxury. We used an instrument designed by the National Council of State Boards of Nursing which surveyed both people who reported nurses for discipline and nurses who have been through discipline. The employers thought it was very effective. Of those nurses who have gone to a Prep program, perhaps two of 200 had a subsequent complaint filed about them.

A Win-Win Situation
Meaningful education creates a win-win situation for systems and for patients. We know the population is aging and that people live longer, so we need to balance protecting the public with ensuring that there are adequate practitioners to provide services to the public. If every minor violation or error that someone makes results with them leaving practice, we have not done a service for the public and we have not made the public any safer. This is why we must look at identifying, remediating, and monitoring people in a nondisciplinary way. Once on site, we educated those who we felt were the key stakeholders in these agencies, including those in human resources as well as the people who might be reporting the person. So we train pharmacy, nursing, human resources and risk management - decision makers and people who are going to be on the front lines.

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You Need to Know Each System and Keep it Informal
Also, what works in one system is not going to work in another, so you need to get to know each system. I think you need to be as informal as possible as well. If you make it too formal and stiff, then people are reluctant to even have a conversation. Assessing or interviewing the person is sometimes as simple as a telephone interview in the hospital. We have never sent someone out of state for a formal assessment. Prep is strictly voluntary and strictly non-public. If the people don’t complete it, they don’t complete it. However, it does stipulate that if they are subsequently reported to the boards within two years for the same type of behavior, they might be subject to disciplinary action, so it does put the licensees on notice.

Some Cases Don’t Go to Prep
There are cases we do not take in Prep, and those are cases that involve drug diversion, reckless conduct, de-
Practitioner Remediation and Enhancement Partnership: Prep 4 Patient Safety

By Julie George

ceiful behavior or sexual misconduct. If there was serious harm or death or someone had a previous disciplinary action, we look at that very closely before we take them. We don’t want the public perception to be that we are shifting someone to a program rather than giving an investigation due diligence. The person could be placed in the program after they have been investigated. The thing that is clearly exclusionary is anything that is drug related.

Types of Referrals Prep Receives
The types of referrals that we get deal primarily with lack of knowledge. They are errors that could possibly be a minor violation of our act, but don’t jeopardize patient’s safety - scope issues, documentation, supervision or delegation issues, and once in a while, breach access to medical records without the need for that.

Documentation
Documentation is a major problem in nursing. That’s especially true with pre-documentation. We see it in long-term care with medication. We have seen it in home care, where nurses may have a lot on their plate. Sometimes they document the wrong thing or don’t fully document. These issues are more the result of bad habits than intentional lying.

Scope Issues
Scope issues are another major problem. There are certain physicians that are negative or nasty, and when these physicians are on call, nurses try to avoid calling them. They know if they call, the physician is going to say, “Can you not figure that out yourself? Can you not do that and I’ll be happy to sign the order in the morning?” And often that kind of behavior is rewarded because the next day the doctor will thank the nurse for not calling him at 3 a.m. It’s reinforcement. But if someone else makes the morning round and refuses to sign the order, that hospital or long-term care reports the nurse’s act for exceeding scope of practice in writing an order or making comments on medications.

Just Culture and Prep
Just culture fits together with Prep in that we are all working at helping people, learning from errors, supporting practitioners and protecting the public. In North Carolina, we have a pilot program where we have worked with just culture. We as a board of nursing are going to partner with hospitals, so that when they handle something in-house and counsel a person, the board is not going to do something diametrically opposite as a regulatory agency. I have been very pleased with the program, and I do think it makes a difference.