ORIGINAL RESEARCH

Exploring How Nursing Schools Handle Student Errors and Near Misses

This study, part 1 of a two-part series, reports survey findings that indicate

In 2000, the Institute of Medicine reported that up to 98,000 people die each year as a result of preventable medical errors.[1] Subsequent estimates by James and by Makary and Daniel indicate that, in actuality, between 210,000 and 440,000 such deaths occur annually.[2,3] During the past 15 years, health care organizations have devoted significant effort toward identifying the causes of medical errors and instituting the necessary changes to improve health care quality and patient safety. But less attention has been paid to understanding how students learn about quality and safety, examining school policies and tools that can help students learn about errors and near misses, and exploring ways to alter curricula and create environments that optimize such learning. This study, part 1 of a two-part series, presents the findings of an investigation of nursing school policies and practices for reporting and tracking student errors and near misses, and for identifying trends. Part 2 will describe strategies that schools can use to create cultures that encourage individual accountability and system effectiveness and support.

that hospital incident reporting systems captured only about 14%.[5] Several reasons have been given for failure to report. One survey of nearly 300,000 health care employees found that 46% felt they couldn't report an error they had caused without fear of retaliation.[6] In the most recent Hospital Survey on Patient Safety Culture by the Agency for Healthcare Research and Quality (AHRQ), several findings suggest that employees don't feel comfortable disclosing errors or near misses.[7] For example:

- 37% worried that their mistakes were recorded in their personnel file.

ABSTRACT
Background:

acknowledging the need for a cultural change toward errors might inadvertently condone their occurrence. There is also concern that if the fact of student errors becomes public knowledge, clinical organizations may be reluctant to have students in their facilities.

There have been relatively few studies investigating nursing student errors and near misses; of these, most have focused on medication errors.[18-20] In one Australian study, Reid-Searl and colleagues interviewed 28 students and found that nine reported making medication errors or near misses.[19] Reasons for errors included a lack of immediate nursing supervision and numerous distractions. Many students said they were told that reporting errors was unnecessary and time consuming. In a study that looked beyond medication errors, Currie and colleagues reported results from a three-year review of web-based student reporting of hazards and near misses.[21] Hazards included infections, equipment and device failures, medication issues, environmental concerns, and issues with documentation and patient identification. Asked whether they had ever been involved in a hazard or near miss, 453 students reported more than 10,000 yes responses; of these, 59% were hazards and 41% were near misses.

In recent years, the need for a fair and just culture in nursing schools has begun to receive wider attention.[16, 22-24] Leaders in this area have been working to apply the principles of safety science, known and used in clinical settings, to nursing school settings. But it's not clear to what extent nursing schools currently have policies that support a contemporary, evidence-based approach to student errors and near misses and to what extent they provide relevant resources to faculty and students.

The purpose of this study was to determine whether prelicensure nursing programs have the following:

- A policy for reporting and follow-up of student errors and near misses
- A tool for reporting student errors and near misses
- A process or tools (or both) for identifying trends
- Strategies for follow-up with students after an error or a near miss
- Strategies for follow-up with clinical agencies or individual faculty members (or both) after student errors or near misses

This study was part of a larger project, funded by the National Council of State Boards of Nursing (NCSBN), in which an occurrence reporting tool was developed and the framework for a national data reporting system and repository was established.[25]

METHODS

Sample. The survey population consisted of nursing schools in the United States that have one or more prelicensure registered nursing programs that prepare students to sit for the National Council Licensure Examination (NCLEX). At the time of the study, there was no single, complete electronic database of all schools of nursing. We obtained a list of schools provided by the NCSBN and manually reviewed each entry. This resulted in a list of 1,667 schools with prelicensure nursing programs. We verified contact information for the dean or director of each school by either using the school's website or calling the school.

Expedited review and approval from the University of Minnesota's institutional review board were obtained before data collection began.

Tool. An invitation to respond in an online survey questionnaire was e-mailed in March 2012 to the deans or directors of the 1,667 nursing schools. A public URL was used so that the person receiving the invitation could forward it to the most appropriate person to complete the survey. Two follow-up reminders were sent, one each month, following the initial invitation. The data collection period was from March 2012 through April 2013.

The survey questionnaire, developed by a panel of content experts from the Quality and Safety Education for Nurses (QSEN) project, contained 20 items. Seven

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- "If safety issue . . . resulted in patient demise, student may be dismissed."
- "The student may be required to conduct a review of the literature on a topic of the professor's choice."
- "We have a 'three strikes and you're out' policy."

Postevent follow-up with clinical agencies. One survey item asked respondents to "discuss your school's and/or faculty's current process for follow-up with clinical agency reporting" as well as "support and/or discipline for students following a clinical error or near miss." A total of 324 respondents (66%) indicated that there was some follow-up with the clinical agency, such as following institutional policy, filling out a facility incident report, reporting the incident to a nurse manager, or a combination of these. Another 95 respondents (19%) did not comment on follow-up with clinical agencies, but did describe some school process for working with students after the event. Thirty-three (7%) reported variability in how follow-up was handled, indicating either that work was under way to develop a formal process or that the school handled situations on a case-by-case basis. Lastly, 14 respondents (3%) replied that the school had no policy in place (and gave no indication that any was forthcoming), and 28 (6%) left the question blank. One respondent commented, "We don't have any process in place, but I will be looking into this issue with the policy and governance committee."

Postevent follow-up with individual faculty. Respondents were then asked to "describe any strategies your school has in place for follow-up with individual faculty if their students have committed errors." A total of 333 respondents (67%) described their school's processes for such follow-up. Respondents indicated a range of actions, including a follow-up call or e-mail from a dean, director, program chair, or department head; individual counseling regarding what happened and what might be helpful in the future; and discussion at the monthly all-faculty meeting. Of the last, one respondent said, "We look on these moments as times to improve on an identified need rather than any sort of blaming process." Yet another said, "We expect the instructors to prevent the medication errors. We have only had one occurrence in the past 15 years of a faculty member not preventing an error. Faculty member was counseled and incident was documented on evaluation." Although the majority of schools reported some follow-up, 113 (23%) indicated there was no specific process in place and 48 (10%) did not answer.

DISCUSSION

Several noteworthy findings emerged. First, half of the responding schools indicated that they had no policy for managing students following a clinical error or near miss, and 55% indicated that they had no tool for reporting student errors or near misses. There may be several reasons for these findings: faculty members may not see student errors and near misses as a priority, or as much of a problem at all; they might be unaware of such events occurring at their school; or they may believe that current school policies and processes adequately address such situations.

It's worth noting that among the additional comments made by respondents, several indicated that faculty members just haven't thought about this issue. One respondent said, "I have never thought about tracking our clinical errors in this manner, but it really has me thinking." Another noted, "As a new department chair . . . I appreciate your study as it makes me mindful of [the] need to track these events and their follow-up." Conversely, some respondents seemed to believe that their students don't make mistakes. As one respondent put it, "Our faculty have the expertise to prevent most errors."

Second, a substantial number of schools reported a lack of consistent standards with regard to student errors and near misses. For example, 29% reported having no consistent standard for differentiating between errors and near misses, 20% reported having no consistent standard in addressing errors or near misses in simulation assignments versus those in clinical settings, and 17% reported having no consistent policy for managing students following a clinical error or near miss. Moreover, five respondents said they didn't know what their school's approach was in these matters. This suggests that conversations among faculty could be helpful in exploring how they regard errors and near misses, how this study's findings might be relevant to their school, and how they might ap-

misses. The findings indicate that the majority of the responding schools lack explicit tools, processes, or policies for consistently addressing student errors or near misses. Furthermore, both respondents' survey answers and the copies of tools and policies provided indicate that significant work is needed to ensure that the principles of a fair and just culture shape how schools respond to these events.

There is abundant evidence that creating a fair and just culture in a given environment promotes open communication, transparency, a commitment to safe practice, and improved outcomes. For nursing schools, some essential first steps are to understand the tools and policies a school has in place; the school's philosophy regarding errors and near misses; the resources needed to establish a fair and just culture; and how faculty can work together to create learning environments that eliminate or minimize the negative consequences of errors and near misses for patients, students, and faculty.

At some schools, the main challenge may be to improve internal communication, rather than to generate new tools and policies or alter the culture. Regardless, our hope is that this study's findings will prompt conversations among faculty: What do we believe about errors and near misses? What underlying philosophy do we want to adopt? How can we educate and support ourselves with regard to student errors and near misses? How will we hold ourselves accountable when such events occur? How can we model for our students a better way to think about errors and near misses? These conversations are essential to ensuring that a nursing school has a fair and just culture in place. In part 2 of this series, we'll describe strategies that faculty can use to do just that.