

# Adverse Event Decision Pathway

## FOR NURSE LEADERS/ADMINISTRATORS

The Adverse Event Decision Pathway (AEDP) was created in response to requests from nurse leaders and boards of nursing for a tool to assist nurse leaders/administrators responsible for evaluation of adverse events and the regulatory reporting of unprofessional conduct or practice errors committed by nurses. This tool was developed in collaboration with nursing leaders from the National Council of State Boards of Nursing (NCSBN) and the American Organization of Nurse Executives (AONE).

Following principles of the systems approach and just culture, the AEDP suggestions include a complete investigation of the adverse event, as well as the nurse's behavioral choices which may have contributed to any adverse event. The AEDP reflects a balance between justice and fairness on the one hand and the need to learn from a mistake and disciplinary action when appropriate on the other hand (Russell & Radtke, 2014).

State boards of nursing (BONs) may also have specific requirements for special or mandatory reporting to the BON. Information regarding reporting requirements is found in the individual state Nurse Practice Act and Rules and Regulations, [www.ncsbn.org/npa.htm](http://www.ncsbn.org/npa.htm). Specific report format and process can be found on the state BON website, [www.ncsbn.org/contact-bon.htm](http://www.ncsbn.org/contact-bon.htm).

## DIRECTIONS

1. In partnership with the facility quality team, conduct an internal investigation on the adverse event occurrence.
2. With your data from the investigation, use the pathway starting with the question at the top, and progress to other questions based on affirmative or negative answers.

## DEFINITIONS

### Board of Nursing

State's governmental agency responsible for the regulation of nursing practice. Includes any other terminology to refer to the regulatory authority (i.e. commission, examiner, department)

### Mitigating Factor

Extenuating, explanatory or justifying fact, situation or circumstance

### Reasonably Prudent Nurse

A nurse who uses good judgment in providing care according to accepted standards

### Remedial Education

Education or training to correct a knowledge or skill deficit

### Substantial Risk

A significant possibility that an adverse outcome may occur

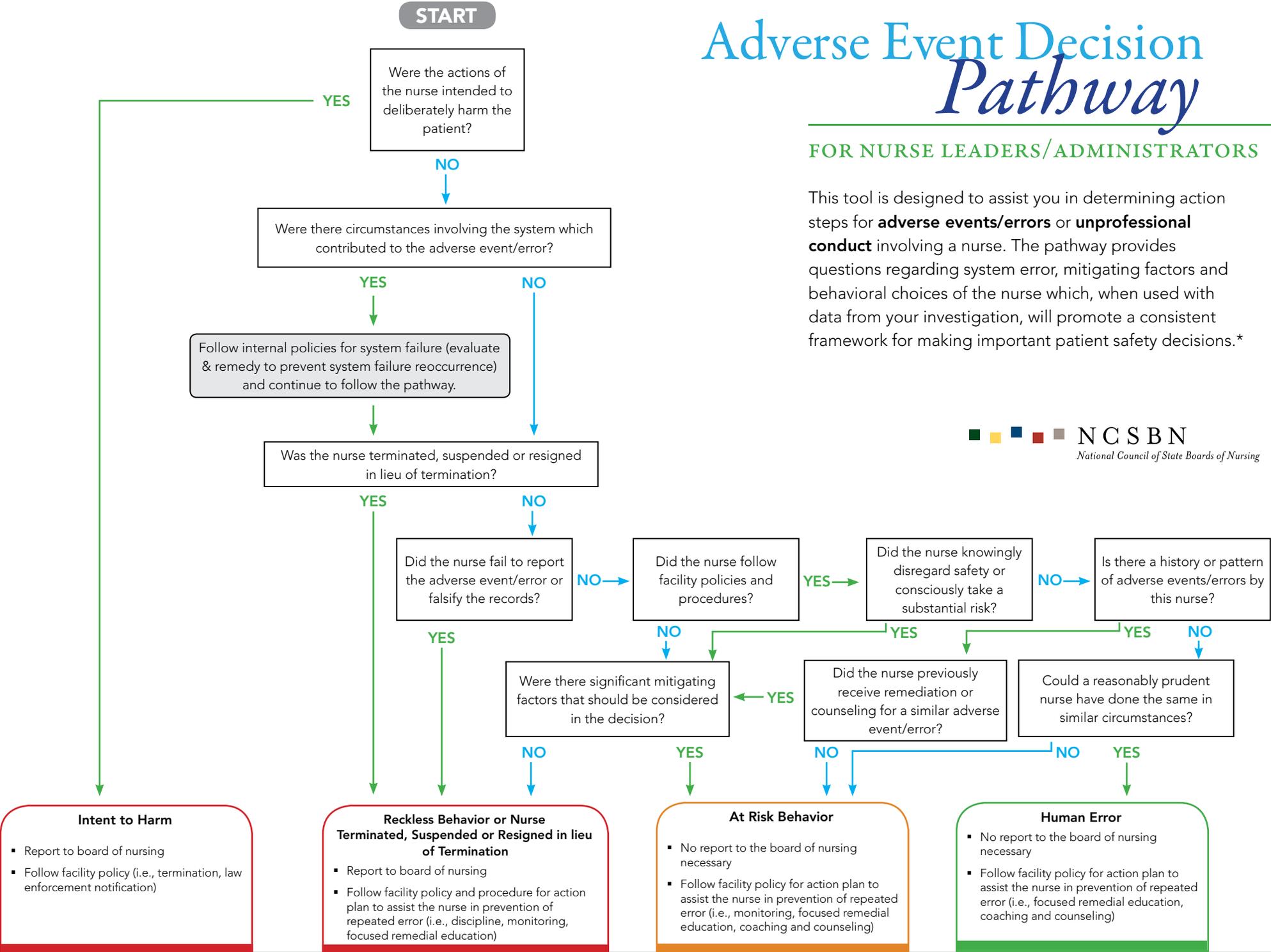
### System

An organization's operational methods, processes or infrastructure/environment

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This tool is designed to assist you in determining action steps for **adverse events/errors** or **unprofessional conduct** involving a nurse. The pathway provides questions regarding system error, mitigating factors and behavioral choices of the nurse which, when used with data from your investigation, will promote a consistent framework for making important patient safety decisions.\*



**Intent to Harm**

- Report to board of nursing
- Follow facility policy (i.e., termination, law enforcement notification)

**Reckless Behavior or Nurse Terminated, Suspended or Resigned in lieu of Termination**

- Report to board of nursing
- Follow facility policy and procedure for action plan to assist the nurse in prevention of repeated error (i.e., discipline, monitoring, focused remedial education)

**At Risk Behavior**

- No report to the board of nursing necessary
- Follow facility policy for action plan to assist the nurse in prevention of repeated error (i.e., monitoring, focused remedial education, coaching and counseling)

**Human Error**

- No report to the board of nursing necessary
- Follow facility policy for action plan to assist the nurse in prevention of repeated error (i.e., focused remedial education, coaching and counseling)

\*In addition to the considerations in the pathway, nurse leaders should be aware of (1) Nurse Practice Act requirements for special or mandatory reporting to the board of nursing and (2) provisions in the state law/regulations for reporting death or serious injury resulting from adverse event/error.