

# **Texas Board of Nursing**

## **Nursing Peer Review Evaluation of Practice-breakdown (N-PREP)**



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# Texas Board of Nursing

## Nursing Peer Review Evaluation of Practice-breakdown (N-PREP)

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# Texas Board of Nursing

## Nursing Peer Review Evaluation of Practice -breakdown (N-PREP)

### I. Overview and Purpose

Nursing Peer Review is required by the Texas Nursing Practice Act (NPA) to promote the delivery of safe, quality nursing care. Nursing Peer Review Committees (Committee) are called upon to fact find, investigate, and analyze nursing practice breakdown events that may indicate there is a deficit in the nurse's ability to provide safe nursing care. The Texas NPA and Board of Nursing's (Board) rules govern nurses in providing safe nursing care and include the Standards of Nursing Practice (Board Rule 217.11)<sup>1</sup>, Unprofessional Conduct (Board Rule 217.12)<sup>2</sup> and mandatory reporting requirements (NPA 301.401).<sup>3</sup>

This is an optional resource offered by the Texas Board of Nursing and is intended to support a Committee's analysis of reported incidents to determine if a nurse's action(s):

- is required to be reported to the Board
- constitutes a minor incident that is not required to be reported to the Board and may be remediated
- does not constitute a deficit in practice

In addition to the regulations outlined above, the Committee should also be very familiar with Board Rule 217.19, related to Incident-Based Nursing Peer Review<sup>4</sup> and Board Rule 217.16, related to Minor Incidents.<sup>5</sup>

Each Committee is encouraged to collect and analyze information obtained through this resource to promote patient safety and the quality of nursing care. As such, the resource may be tailored to meet specific organizational needs. However, Sections **III**, **IV**, and **VI** regarding the Board's rules about the reporting of infractions of the Nursing Practice Act, standards of nursing practice, and unprofessional conduct should not be modified.

### II. Directions

This resource acts as template for evaluating the nursing practice breakdown event. Each section of this instrument provides direction related to that section and how it fits into the larger picture of analyzing the nursing practice breakdown.

The Committee should follow the resource for a thorough evaluation of the event. However, the Committee members may determine that reporting to the Board is required without the need to exhaust the steps outlined in this resource based on an evaluation of known facts about the events surrounding the nursing practice breakdown. In this situation, the Committee members may wish to go directly to the mandatory reporting sections in Section **III** and **VI**. In instances where the nurse is reported to the Board prior to use of this resource, the Committee should conduct its review of system factors and/or external factors beyond the nurse's control by proceeding to Section **V(b-c)**.<sup>4</sup>

As indicated, the Nursing Peer Review of Practice-breakdown (N-PREP) is a voluntary resource for the nursing peer review process and the information gleaned from this analysis is intended for facility level use.

It is strongly recommended that utilization of N-PREP is preceded by reviewing an orientation module that provides a thorough explanation of the resource. This orientation can be found on the Board website at [www.bon.texas.gov](http://www.bon.texas.gov). under the Practice heading then selecting from the drop-down menu Nursing Peer Review Evaluation of Practice-breakdown (N-PREP).





## Board Rule 217.11 Standards of Nursing Practice

From the list below, identify any and all practice standards found in Board Rule 217.11 that were **not met** during the nursing practice breakdown event.

- Know and conform to the Texas Nursing Practice Act and the Board's rules and regulations as well as all federal, state, or local laws, rules or regulations affecting the nurse's current area of nursing practice.
- Implement measures to promote a safe environment for clients and others.
- Know the rationale for and the effects of medications and treatments and shall correctly administer the same.
- Accurately and completely report and document: the client's status including signs and symptoms; nursing care rendered; physician, dentist or podiatrist orders; administration of medications and treatments; client response(s); and contacts with other health care team members concerning significant events regarding client's status.
- Respect the client's right to privacy by protecting confidential information unless required or allowed by law to disclose the information.
- Based on health needs, promote and participate in education and counseling to a client(s) and, where applicable, the family/ significant other(s).
- Obtain instruction and supervision as necessary when implementing nursing procedures or practices.
- Make a reasonable effort to obtain orientation/training for competency when encountering new equipment and technology or unfamiliar care situations.
- Notify the appropriate supervisor when leaving a nursing assignment.
- Know, recognize, and maintain professional boundaries of the nurse-client relationship.
- Provide, without discrimination, nursing services regardless of the age, disability, economic status, gender, national origin, race, religion, health problems, or sexual orientation of the client served.
- Institute appropriate nursing interventions that might be required to stabilize a client's condition and/or prevent complications.
- Clarify any order or treatment regimen that the nurse has reason to believe is inaccurate, non-efficacious or contraindicated by consulting with the appropriate licensed practitioner and notifying the ordering practitioner when the nurse makes the decision not to administer the medication or treatment.
- Implement measures to prevent exposure to infections pathogens and communicable conditions.
- Collaborate with the client, members of the health care team and, when appropriate, the client's significant other(s) in the interest of the client's health care.
- Consult with, utilize, and make referrals to appropriate community agencies and health care resources to provide continuity of care.
- Be responsible for one's own continuing competence in nursing practice and individual professional growth.
- Make assignments to others that take into consideration client safety and that are commensurate with the educational preparation, experience, knowledge, and physical and emotional ability of the person to whom the assignments are made.
- Accept only those nursing assignments that take into consideration client safety and that are commensurate with the nurse's educational preparation, experience, knowledge, and physical and emotional ability.

- Supervise nursing care provided by others for whom the nurse is professionally responsible.
- When acting in the role of nurse administrator, ensure the verification of current Texas licensure or other Compact State licensure privilege and credentials of personnel for whom the nurse is administratively responsible.
- Perform nursing assessment(s) within the scope of practice for the licensure level.
- Develop or participate in the development of the nursing plan of care within the scope of practice for licensure level.
- Implement nursing care within the scope of practice for the licensure level.
- Evaluation of client's response(s) within the scope of practice for the licensure level.
- (For RNs, including APRNs ONLY) Delegate tasks to unlicensed personnel in compliance with the appropriate Board of Nursing Rules and Regulations chapter of delegation rule (Chapter 224 or Chapter 225).<sup>7</sup>
- (For APRNs ONLY) Prescribe medications in accordance with prescriptive authority granted under Board Chapter 222<sup>8</sup> and standards within that chapter and in compliance with state and federal laws and regulations relating to prescription of dangerous drugs and controlled substances.

### **Board Rule 217.12 Unprofessional Conduct<sup>2</sup>**

**Unprofessional Conduct Rule 217.12 identifies behaviors in practice that are likely to deceive, defraud or injure clients. Actual injury to a client need not be established. The behaviors outlined below do not incorporate all of aspects of 217.12 but are those that most often relate to nursing practice breakdown and are not covered by other sections of this N-PREP Resource. Identify any and all unprofessional conduct in this section that occurred during the nursing practice breakdown event.<sup>2</sup> When determining whether or not a report to the Board is needed, the Committee should carefully evaluate the nurse's behavior including intent, as well as the nature, seriousness and implications of the conduct.**

- Carelessly failing, repeatedly failing, or exhibiting an inability to perform vocational, registered, or advanced practice nursing in conformity with the standards of minimum acceptable level of nursing practice set out in Rule 217.11.
- Conduct that may endanger a client's life, health or safety.
- Threatening or violent behavior in the workplace.
- Demonstrating actual or potential inability to practice nursing with reasonable skill and safety to clients by reason of illness, use of alcohol, drugs, chemicals, or any other mood-altering substances, or as a result of any mental or physical condition.
- Misappropriating, in connection with the practice of nursing, anything of value or benefit, including but not limited to, any property, real or personal of the client, employer, or any other person or entity, or failing to take precautions to prevent such misappropriation.
- Falsification of or making incorrect, inconsistent, or unintelligible entries in any agency, client, or other record pertaining to drugs or controlled substances.
- Failing to follow the policy and procedure in place for the wastage of medications at the facility where the nurse was employed or working at the time of the incident(s).
- Obtaining or attempting to obtain or deliver medication(s) through means of misrepresentation, fraud, forgery, deception and/or subterfuge

## V. Nurse, Patient, and System Factors Involved in the Nursing Practice Breakdown<sup>9</sup>

Improvement in patient safety will not be accomplished by focusing on discrete errors alone.<sup>6</sup> Concurrent with the review of the nursing practice breakdown, there should be a review of those factors in the health care system that may have also contributed to the error event. This instrument provides a comprehensive template for the selection of factors that contributed to the event including nurse, patient, system and healthcare team factors. The Committee may then determine the appropriate course of action regarding remediation.

### a. Nurse Characteristics

This section describes the nurse involved in the nursing practice breakdown and obtains characteristics about that nurse that should be taken in consideration related to the nursing practice breakdown as the Committee analyzes the event. Consider additional/other nurse data as appropriate to tailor to your facility needs.

**1. What is the highest nursing degree held by the nurse at the time of the nursing practice breakdown?**

- Diploma
- ADN
- Alternate Entry
- BSN
- Graduate
- Vocational Certificate
- Unknown

**2. What is the highest licensure level held by the nurse at the time of the nursing practice breakdown?**

- LVN
- RN
- APRN
- Unknown

**3. What is the year of the nurse's initial licensure at their highest licensure level, if known?**

\_\_\_\_\_

**4. Was the nurse on orientation at the time of the nursing practice breakdown?**

- Yes
- No

**5. Length of time the nurse worked in the patient care location/unit/department where the nursing practice breakdown occurred.**

- Less than one month
- 1-11 months
- 1 yr-less than 3 yrs
- 3 yrs- less than 5 yrs
- 5 yrs or more
- Unknown

**6. What type of shift was the nurse working at the time of the nursing practice breakdown?**

**This information will help determine if there are particular types of shifts where more nursing practice breakdown occurs.**

- 8 hour
- 10 hour
- 12 hour
- On Call
- Other \_\_\_\_\_
- Unknown

**7. Was the nurse working in a temporary capacity (i.e. traveler, float pool, float to another unit, or covering a patient for another nurse)? Nurses in a temporary capacity may not be familiar with the environment or be as experienced with the type of nursing care.**

- Yes
- No
- Unknown

**8. What was the nurse's patient assignment at the time of the nursing practice breakdown? Consider the number of patients assigned and their acuity.**

- No patients
- Less than usual patient load
- More than usual patient load
- Usual patient load
- Unknown

## b. Patient Characteristics<sup>9</sup>

This section examines characteristics of the patient involved in the nursing practice breakdown event. Collecting and aggregating this data provides the opportunity to identify common patient characteristics that may contribute to nursing practice breakdown. Consider additional/other patient data as appropriate, to tailor to your facility needs. Please check all that apply. \*Notes questions that have examples provided in Appendix A.

### 9. Patient age.

\_\_\_\_\_  Unknown

### 10. Patient sex.

- Male
- Female
- Other
- Unknown

### 11. Patient's diagnosis. The patient's diagnoses may contribute to the context of nursing practice breakdown.

- Endocrine, metabolic, & immune systems disease/ disorder
- Genitourinary system disease/ disorder
- Heart & circulatory system disease/ disorder
- Mental health conditions
- Musculoskeletal system disease/ disorder
- Nervous system or sense organ disease/ disorder
- Pregnancy, childbirth, & related conditions/ complications
- Injury/ trauma
- Respiratory system disease/ disorder
- Skin disease/ disorder
- Systemic infections/ infectious diseases (bacterial, viral, & parasitic)
- Other \_\_\_\_\_

### 12. What was the complexity of the patient involved at the time of the nursing practice breakdown? The complexity of the patient may affect or contribute to nursing practice breakdown.

- Less complex than the average
- Average complexity
- More complex than average

### 13. Characteristics the patient exhibited that were involved in the nursing practice breakdown.

- Agitation/ combativeness/violence
- Altered level of consciousness
- Communication/ language difficulty
- Depression/ anxiety
- Inadequate coping/ stress management
- Incontinence
- Insomnia
- Cognitive Impairment
- Pain
- Sensory deficits (hearing, vision, touch)
- Other \_\_\_\_\_

### 14. Impact of the nursing practice breakdown on the level of patient harm.\*

- No harm
- Harm
- Serious Injury
- Death

## c. System Factors<sup>9</sup>

System factors are elements found within an organization and may be beyond the nurse's control that impact nursing practice. Examining components of the system that may have contributed to the nursing practice breakdown provides the opportunity to address those system factors and prevent similar nursing practice breakdown in the future. Consider additional/other nurse data as appropriate, to tailor to your facility needs. Please check all that apply. \*Notes questions that have examples provided in Appendix A.

### Leadership & Management Factors

**15. Did factors related to leadership and management contribute to the nursing practice breakdown? The leadership and management style of hospital authorities, chief nursing officers, and administrators can impact patient safety within the organizational culture.\***

- Inadequate supervision/support by others
- Unclear scope and limits of authority/responsibility
- Inadequate/ outdated policies/ procedures
- Assignment or placement of inexperienced personnel
- Nurse shortage, sustained, at institutional level
- Inadequate patient classification (acuity) system to support appropriate staff assignments
- Other \_\_\_\_\_

### Communication Systems Factors

**16. Did factors related to communication systems contribute to the nursing practice breakdown? The transfer (or lack of transfer) of patient information is frequently cited in the patient safety literature as a critical element in providing safe and effective patient care.\***

- Communication systems equipment failure
- Interdepartmental communication breakdown/conflict
- Shift change (patient hand-offs)
- Patient transfer (hand-offs)
- Inadequate channels for resolving disagreements
- Preprinted orders inappropriately used (other than medications)
- Medical record/ electronic health record not accessible
- Patient name similar/ same
- Patient identification failure
- Lack of or inadequate orientation/ training
- Computer system/ technology failure
- Lack of ongoing education/ training
- Other \_\_\_\_\_

### Environmental Factors

**17. Did environmental factors contribute to the nursing practice breakdown? The environment is a component of the organization that provides the context for the delivery of safe patient care.\***

- Poor lighting
- Increased noise level
- Frequent interruptions/ distractions
- Lack of adequate supplies/ equipment
- Equipment failure
- Physical hazards
- Multiple emergency situations
- Similar/ misleading labels (other than medications)
- Disaster
- Code situation
- Other \_\_\_\_\_

### Backup & Support Factors

**18. Did backup and support factors play a role in the nursing practice breakdown? Having resources in place for the unexpected is an important consideration in providing health care services.\***

- Ineffective system for provider coverage
- Lack of adequate provider response
- Lack of nursing expertise system for support
- Forced choice in critical circumstances
- Lack of adequate response by lab/ x-ray/ pharmacy or other department
- Other \_\_\_\_\_

### Staffing Issues

**19. Did staffing issues contribute to the nursing practice breakdown? Staffing involves a multifocal approach to ensure safe patient care.\***

- Lack of supervisory/ management support
- Lack of experienced nurses
- Lack of nursing support staff
- Lack of clerical support
- Lack of other health care team support
- Other \_\_\_\_\_



## Health Team Members Involved in the Nursing Practice Breakdown

**20. Did a member of the health care team contribute to the nursing practice breakdown? Multidisciplinary teams work together to provide patient care. Another member of the health care team may have contributed to the nursing practice breakdown of the nurse in question.\***

- Supervisory nurse/ personnel
- Physician (may be attending, resident, or other)
- Other prescribing provider
- Pharmacist
- Additional staff nurse
- Floating or temporary staff
- Other health professional (e.g. PT, OT, RT)
- Health profession student
- Medication assistant
- Other support staff
- Unlicensed assistive personnel (nurse aide, certified nursing assistant, CNA or other titles of non-nurses who assist in performing nursing tasks)
- Patient
- Patient's family/ friend
- Other \_\_\_\_\_

## Healthcare Team Factors

**21. Was there a healthcare team factor involved in the nursing practice breakdown? This question provides an opportunity to identify factors relating to the culture of a facility and how members of the health care team interact with each other.\***

- Intradepartmental conflict/ non-supportive environment
- Breakdown in health care team communication
- Lack of multidisciplinary care planning
- Intimidating/ threatening behavior
- Lack of patient involvement in plan of care
- Care impeded by policies or unwritten norms that restrict communication
- Majority of staff had not worked together previously
- Lack of patient education
- Lack of family/ caregiver education
- Other \_\_\_\_\_

## VI. Determination of Reporting<sup>3,4</sup>

Each section of this resource should be analyzed to identify and weigh the various characteristics and factors that played a role in the nursing practice breakdown event. For example, if there were standards that were not met, did the nurse take appropriate measures to try and meet the standards? Reflecting on the Committee's evaluation of each of the sections in the N-PREP, the following are questions to aid the Committee in reporting systems factors and determining whether or not a nurse is subject to being reported to the Texas Board of Nursing. The questions will include instructions for how the committee is to proceed based on their determination.

### 22. Were there any system factors and/or external factors beyond the nurse's control that may have contributed to the nursing practice breakdown?

- If **YES**, these findings must be reported to the **Patient Safety Committee** and if the facility does not have a Patient Safety Committee the report should go to the **CNO**. **Continue to next question.**
- If **NO**, continue to next question.

### 23. Was there a deficit in the nurse's practice including any identified issues related to 217.11 and 217.12 in Section V that contributed to the nursing practice breakdown?

- If **NO**, report to the Board not needed.
- If **YES**, continue to next question.

### 24. Did the nurse's practice breakdown contribute to the death or serious injury of the patient?

- If **YES**, the nurse must be reported to the Board.\*\*
- If **NO**, continue to next question.

### 25. Did the nurse's practice breakdown indicate that the nurse lacked knowledge, skill, judgment, or conscientiousness to such an extent that the nurse's continued practice of nursing could reasonably be expected to pose a risk of harm to a patient or another person, regardless of whether the conduct consists of a single incident or a pattern of behavior?

- If **YES**, and the Committee determines the nurse's continued practice of nursing could pose a risk of harm to a patient or another person then the **nurse must be reported to the Board.**\*\*
- If **NO** or further evaluation is needed to determine if the nurse's continued practice poses a risk of harm to a patient or another person then **continue to next question.**

### 26. Can the nurse be remediated to correct the deficiencies identified in the nurse's judgement, knowledge, training or skill?

- If **NO**, the nurse must be reported to the Board.\*\*
- If **YES**, continue to the next question.

### 27. What remediation will be used? Refer to the specific type of breakdown in the nurse's practice as determined in Section IV to develop the remediation plan. In addition, further assistance with remediation can be found in Appendix B which provides a framework that may be useful in identifying the precipitating causes of the nursing practice breakdown.

If the Committee determines a remediation plan is appropriate for this event, tracking needs to occur to ensure the nurse completes the remediation and is deemed safe to practice. If the nurse completes the remediation plan, documentation should be retained. If the remediation plan is not completed or the nurse terminates employment prior to its completion, a determination should be made at that point in time:

- if the nurse has completed sufficient remediation to be deemed safe to practice;
- if a report should be made to the nursing peer review committee of the nurse's new employer (with the nurse's consent); or
- if a report to the Board is needed.

\*\*When the Committee determines it is required to report a nurse to the Board, the Committee shall submit to the Board a written, signed report that includes the following requirement information per Board Rule 217.19(i)(4).

- The identity of the nurse
- A description of the conduct subject to reporting

- A description of any corrective action taken against the nurse
- A recommendation as to whether the Board should take formal disciplinary action against the nurse, and the basis for the recommendation
- The extent to which any deficiency in care provided by the reported nurse was the result of a factor beyond the nurse's control and
- Any additional information the Board requires.

The Board's forms are not required to make a report but may be used to meet the requirements found in Board Rule 217.19(i)(4). Those forms can be found on the Board website under **Discipline and Complaints** then selecting from the drop down menu **How to File a Complaint**.

- Written complaint form for Nursing Peer Review Committees

If a determination has been made to report the nurse to the Board, the Committee may submit the findings of the N-PREP review as supporting documentation to the Board's required reporting information.

## APPENDIX A:

### Section V: Nurse, Patient and System Factors Involved in the Nursing Practice Breakdown Examples<sup>7</sup>

#### 14. Impact of the nursing practice breakdown on the level of patient harm.

##### NO HARM

An error occurred but with no harm to the patient.

##### Examples:

- Nurse Trevor received an order to start an IV. As he was preparing the solution in the Medication Room, Nurse Joan observed that the solution was D5W instead of the ordered Normal Saline solution.
- Nurse Carla failed to administer a patient's medication, but the patient did not experience any ill effects.
- Nurse Mary did not thoroughly assess the patient's changing condition, but the following shift identified the situation quickly and intervened before the patient deteriorated.

##### HARM

An error occurred that contributed to a minor negative change in the patient's condition.

##### Examples:

- Nurse Colleen forgot to turn on the alarm for the patient's pulse oximetry. The patient's O<sub>2</sub> saturation decreased to 90% requiring the patient to remain on oxygen for a longer period.
- Nurse John made a medication error that required a transfer to a higher level of care in the ICU.

##### SERIOUS INJURY

An error occurred that contributed to significant harm which involves serious physical or psychological injury.

##### Examples:

- Nurse Margaret administered a second dose of a penicillin type antibiotic without verifying the patient's allergy status. The patient suffered an anaphylactic reaction and respiratory arrest requiring cardiopulmonary resuscitation and transfer to the ICU.
- Nurse Steve failed to assess the feet of a diabetic patient; the patient developed a wound resulting in foot amputation.

##### DEATH

An error occurred that may have contributed to or resulted in patient death.

##### Examples:

- Nurse Sharon failed to assess a patient who appeared to be sleeping; the charge nurse assessed the patient and discovered the patient had suffered a respiratory arrest and was dead.
- Nurse Robbie calculated a conversion incorrectly and gave ten times the dose of a medication resulting in the patient's death.
- Nurse Andrea misread the type of insulin and gave the wrong type/strength resulting in the patient's death.

# System Factors

## Leadership & Management Factors

### 15. Did leadership and management factors contribute to the nursing practice breakdown?

<b>Inadequate supervision/ support by others</b>	<b>Examples:</b> <ul style="list-style-type: none"><li>■ Preceptor Amy did not monitor new nurse Bill performing a treatment for the first time; Bill did not follow the facility procedure resulting in an error.</li><li>■ Nurse Joan was floated to a unit that she had never worked before and given a very unstable patient by the charge nurse. The charge nurse did not respond to a request for help from Nurse Joan.</li></ul>
<b>Unclear scope and limits of authority/ responsibility</b>	<b>Examples:</b> <ul style="list-style-type: none"><li>■ Nurses were unclear as to their roles in directing EMTs working in the Emergency Department.</li><li>■ Staff were unclear regarding ICU nurses and respiratory care therapist roles and responsibilities in the operation and maintenance of ventilators.</li></ul>
<b>Inadequate/ outdated policies/ procedures</b>	<b>Examples:</b> <ul style="list-style-type: none"><li>■ The equipment that was being used did not align with the facility policies and procedures.</li><li>■ Emergency policies were not current with ACLS training and certification thus causing confusion during a code.</li><li>■ The APRN's delegation protocol referenced the use of the most current edition of the text "Clinical Guidelines in Family Practice" for determining the standard of care. The only available copy of this text for the APRN's use was an older edition of the text.</li></ul>
<b>Assignment or placement of inexperienced personnel</b>	<b>Example:</b> <ul style="list-style-type: none"><li>■ An adult medical-surgical nurse was floated to a pediatrics unit and was not given an orientation to the unit.</li></ul>
<b>Nurse shortage, sustained, at institution level</b>	<b>Example:</b> <ul style="list-style-type: none"><li>■ For several weeks, a hospital had a continually high census and was not staffed with a full complement of nurses. The problem became critical when there was a serious and sustained increase in patient acuity.</li></ul>
<b>Inadequate patient classification (acuity) system to support appropriate staff assignments</b>	<b>Examples:</b> <ul style="list-style-type: none"><li>■ The lack of a valid and reliable patient classification system resulted in inadequate staffing.</li><li>■ The acuity classification system had been revised numerous times to the point that the nurse making the assignments was confused.</li></ul>

## Communication Systems Factors

### 16. Did communication systems factors contribute to the nursing practice breakdown?

<p><b>Communication systems equipment failure</b></p>	<p><b>Example:</b></p> <ul style="list-style-type: none"> <li>■ <i>The nurses' intercom call light system frequently malfunctioned resulting in patients being unable to summon assistance.</i></li> </ul>
<p><b>Interdepartmental communication breakdown/ conflict</b></p>	<p><b>Examples:</b></p> <ul style="list-style-type: none"> <li>■ <i>Patient units A &amp; B staff disagreed on the process for cross training between units; the conflict affected other unit interactions.</i></li> <li>■ <i>The Emergency Department and Lab disagreed on how lab values should be reported. The resulting confusion led to a critical lab value being overlooked.</i></li> </ul>
<p><b>Shift change (patient hand-offs)</b></p>	<p><b>Examples:</b></p> <ul style="list-style-type: none"> <li>■ <i>The lack of communication between shifts resulted in a failure to communicate changes in a patient's condition, medication change and new treatment.</i></li> <li>■ <i>A recent policy change required shift report to be done at the bedside. Nurse Ellen complied with this change but because of the extra time requirement, did not complete her documentation.</i></li> </ul>
<p><b>Patient transfer (hand-offs)</b></p>	<p><b>Example:</b></p> <ul style="list-style-type: none"> <li>■ <i>Nurse Max did not call a report to the unit receiving the patient transferred from his department.</i></li> </ul>
<p><b>Inadequate channels for resolving disagreements</b></p>	<p><b>Example:</b></p> <ul style="list-style-type: none"> <li>■ <i>A nurse and a resident physician disagreed over a patient's care; there was no means to resolve the disagreement resulting in continued friction between the two which impacted patient care.</i></li> </ul>
<p><b>Preprinted orders inappropriately used (other than medications)</b></p>	<p><b>Example:</b></p> <ul style="list-style-type: none"> <li>■ <i>A pre-printed order was not customized to the patient and an allergy warning was not recorded.</i></li> </ul>
<p><b>Medical record not accessible</b></p>	<p><b>Examples:</b></p> <ul style="list-style-type: none"> <li>■ <i>The unit clerk did not add the I&amp;O sheets to the patient's chart in a timely manner resulting in the patient's nurse being unable to review the previous 24-hour totals.</i></li> <li>■ <i>The EHR system was inaccessible contributing to several missed orders.</i></li> </ul>

## 16. Did communication systems factors contribute to the nursing practice breakdown? Continued

<b>Patient name similar/ same</b>	<b>Example:</b> <ul style="list-style-type: none"><li>■ <i>Two patients had the same last name, causing a mix-up in their orders.</i></li></ul>
<b>Patient identification failure</b>	<b>Examples:</b> <ul style="list-style-type: none"><li>■ <i>The patient's name bracelet was difficult to read. This resulted in a nurse misidentifying the patient.</i></li><li>■ <i>The hospital arm band scanning system did not differentiate between two patients with the same name.</i></li></ul>
<b>Computer system failure/ technology</b>	<b>Example:</b> <ul style="list-style-type: none"><li>■ <i>Nurse Lilly was unable to check for new medical orders because the computer system was down. The patient did not receive a one-time Lasix dose as prescribed.</i></li></ul>
<b>Lack of or inadequate orientation/training</b>	<b>Examples:</b> <ul style="list-style-type: none"><li>■ <i>The scheduled orientation for a new nurse included several shifts where she would "buddy" with another nurse to provide patient care. Due to a shortage of staff, the charge nurse assigned the nurse six patients to care for without the buddy. The new nurse was not able to complete the assignment and some aspects of patient care were not provided.</i></li><li>■ <i>Nursing supervisor David, believing that experienced nurse Regina had no need for orientation to a new practice environment, did not schedule her for training. In the first week Regina failed to follow the organization's Infection Control policy.</i></li></ul>
<b>Lack of ongoing education/training</b>	<b>Example:</b> <ul style="list-style-type: none"><li>■ <i>New equipment was placed on the unit with no training offered or available. All nurses were expected to use the new equipment. Nurse Faye did not set up the equipment correctly and the patient did not receive the ordered treatment.</i></li></ul>

## Environmental Factors

17. Did environmental factors contribute to the nursing practice break down?	
Poor lighting	<p><b>Example:</b></p> <ul style="list-style-type: none"> <li>The light in the medication room was out and Maintenance did not respond, leading to a long delay in medication administration.</li> </ul>
Increased noise level	<p><b>Example:</b></p> <ul style="list-style-type: none"> <li>Nurse Norma could not concentrate on calculating an IV dosage because of construction on the unit; subsequently she made a mathematical error.</li> </ul>
Frequent interruptions/distractions	<p><b>Example:</b></p> <ul style="list-style-type: none"> <li>Nurse Nancy was constantly interrupted during her morning medication rounds and omitted one patient's medication.</li> </ul>
Lack of adequate supplies/equipment	<p><b>Example:</b></p> <ul style="list-style-type: none"> <li>Nurse Yolanda was unable to administer a treatment because the equipment was missing.</li> </ul>
Equipment failure	<p><b>Example:</b></p> <ul style="list-style-type: none"> <li>A patient coded. The telemetry leads were cracked and did not work.</li> </ul>
Physical hazards	<p><b>Example:</b></p> <ul style="list-style-type: none"> <li>Nurse Paul, while assisting a patient to ambulate, tripped over material left in the hallway, causing both to fall.</li> </ul>
Multiple emergency situations	<p><b>Example:</b></p> <ul style="list-style-type: none"> <li>Two codes occurred at the opposite ends of the hall; there was only one emergency cart on the unit.</li> </ul>
Similar/misleading labels (other than medications)	<p><b>Example:</b></p> <ul style="list-style-type: none"> <li>Nurse Sheila grabbed a bottle of sterile saline to use in a treatment and did not realize that she had gotten another solution with a similar bottle and label.</li> </ul>
Disaster	<p><b>Example:</b></p> <ul style="list-style-type: none"> <li>A hurricane caused power outages and flooding within the facility, leading to failure of the back-up generators. With poor lighting in the unit, Nurse Matt made a central line tubal misconnection.</li> </ul>
Code Situation	<p><b>Example:</b></p> <ul style="list-style-type: none"> <li>Nurse Perry misunderstood the verbal order given during a code situation and administered the wrong dose of a medication.</li> </ul>



## Backup & Support Factors

### 18. Did backup and support factors play a role in the nursing practice breakdown?

<b>Ineffective system for provider coverage</b>	<b>Example:</b> <ul style="list-style-type: none"><li>■ <i>The medical department did not inform the patient units that resident physicians were unavailable to cover patient needs because of sitting for national examinations. Nor did they notify the attending physicians that they were to provide coverage.</i></li></ul>
<b>Lack of adequate provider response</b>	<b>Examples:</b> <ul style="list-style-type: none"><li>■ <i>Physician Ben was notified of a critical change in the patient's condition and failed to issue any orders.</i></li><li>■ <i>APRN Julia encountered a patient care situation that was beyond her scope of practice. She attempted to text, call and page the delegating physician, but the physician did not respond.</i></li></ul>
<b>Lack of nursing expertise system for support</b>	<b>Example:</b> <ul style="list-style-type: none"><li>■ <i>A patient was ordered to have a procedure that none of the nurses or supervisor on the shift had performed. No other orientation/supervision was available so the procedure was delayed for several hours.</i></li></ul>
<b>Forced choice in critical circumstances</b>	<b>Examples:</b> <ul style="list-style-type: none"><li>■ <i>Nurse Sally had only worked on a Med/Surg Unit. She received a critically ill patient on her unit because there were no ICU beds or staff.</i></li><li>■ <i>Nurse George received multiple trauma patients in the ED at the same time, resulting in many patients not receiving timely assessments.</i></li></ul>
<b>Lack of adequate response by lab /x-ray/ pharmacy or other department</b>	<b>Examples:</b> <ul style="list-style-type: none"><li>■ <i>In a small, rural facility, there was no replacement while the lab tech was on vacation and the Nursing Department was not notified. This resulted in several patients missing lab work.</i></li><li>■ <i>Stat laboratory tests were ordered but not completed by the lab in a timely manner.</i></li><li>■ <i>Security officers were summoned to assist with an agitated visitor but did not respond to the page.</i></li></ul>

## Staffing Issues

19. Did staffing issues contribute to the nursing practice breakdown?	
<b>Lack of supervisory/management support</b>	<b>Example:</b> <ul style="list-style-type: none"><li>■ <i>Due to several new admissions, the supervisor did not respond to a nurse who requested additional staff.</i></li></ul>
<b>Lack of experienced nurses</b>	<b>Example:</b> <ul style="list-style-type: none"><li>■ <i>Enough nurses were assigned to an evening shift, but only one regularly worked on the unit; others were float or agency personnel.</i></li></ul>
<b>Lack of nursing support staff</b>	<b>Examples:</b> <ul style="list-style-type: none"><li>■ <i>Housekeeping had frequent staffing issues requiring nurses to routinely take over those responsibilities impacting their prioritization of patient care.</i></li><li>■ <i>A nursing assistant was regularly floated to another unit and not replaced despite an increase in census and several critically ill patients.</i></li></ul>
<b>Lack of clerical support</b>	<b>Example:</b> <ul style="list-style-type: none"><li>■ <i>There was no clerical help at night despite an ongoing trend in new admissions.</i></li></ul>
<b>Lack of other health care team support</b>	<b>Example:</b> <ul style="list-style-type: none"><li>■ <i>There was no respiratory therapist assigned to the night shift despite multiple ventilator dependent patients needing ongoing support.</i></li></ul>

## Health Team Members Involved in the Nursing Practice Breakdown

20. Did a member of the health care team contribute to the nursing practice breakdown?	
Supervisory nurse/ personnel	<p><b>Examples:</b></p> <ul style="list-style-type: none"> <li>■ On an extremely busy shift, charge nurse Rachel told staff she was busy and to work out problems on their own.</li> <li>■ Charge nurse Tony left the floor on a nonscheduled smoke break without notifying anyone. A patient fell, and the assigned nurse needed help.</li> </ul>
Physician (may be attending, resident, or other)	<p><b>Examples:</b></p> <ul style="list-style-type: none"> <li>■ Ignoring hospital policy, the physician told the nurse to take a verbal order for a medication. The nurse administered the wrong dosage of medication because she misheard the verbal order.</li> <li>■ A physician told the nurse, "Don't call me - I don't care what happens I've been up for 36 hours". Consequently, the nurse decided not to call the physician when the patient had a serious change in condition.</li> </ul>
Other prescribing provider	<p><b>Example:</b></p> <ul style="list-style-type: none"> <li>■ A physician's assistant wrote admission orders for a new patient including an order for a MRI. The patient insisted that he had the ordered MRI the day before and did not need the procedure again. The nurse did not check with the X-Ray Department or clarify the MRI order with the physician's assistant.</li> </ul>
Pharmacist	<p><b>Example:</b></p> <ul style="list-style-type: none"> <li>■ The Pharmacy sent the wrong antipsychotic medication to the unit. Nurse Victor failed to review the MAR before administering the medication to the patient.</li> </ul>
Additional staff nurse	<p><b>Example:</b></p> <ul style="list-style-type: none"> <li>■ A patient in a psychiatric setting became violent with other patients and had to be placed in seclusion. Because of chaos on the unit, Nurse Charles forgot to inform the physician and request an order for the seclusion. Nurse Julie took over at shift change and, assuming that the physician had been notified, did not notify medical staff. This resulted in medical staff being unaware of a secluded patient for 24 hours.</li> </ul>
Floating or temporary staff	<p><b>Example:</b></p> <ul style="list-style-type: none"> <li>■ Nurse Ruth was floated to pediatrics from L&amp;D. She answered the patient's call light and provided interventions. She failed to document or notify the assigned nurse of these actions.</li> </ul>
Other health professional (e.g. PT, OT, RT)	<p><b>Example:</b></p> <ul style="list-style-type: none"> <li>■ OT staff did not raise the bed rails after working with the patient. Nurse Jean was late from her lunch break and the patient had fallen out of the bed.</li> </ul>
Health profession student	<p><b>Example:</b></p> <ul style="list-style-type: none"> <li>■ A medical student accidentally discontinued the wrong IV line and did not alert the patient's nurse.</li> </ul>



## 20. Did a member of the health care team contribute to the nursing practice breakdown? Continued

<p><b>Medication assistant</b></p>	<p><b>Example:</b></p> <ul style="list-style-type: none"> <li>■ Because of several new admissions, Nurse Judy asked the medication assistant to also give medications to a few of her patients. The medication assistant forgot to give the meds.</li> </ul>
<p><b>Other support staff</b></p>	<p><b>Example:</b></p> <ul style="list-style-type: none"> <li>■ Dietary staff mistakenly delivered a tray to the unit for a patient that had NPO orders. Nurse Veronica delivered the tray to the patient who ate the meal. The patient's surgery had to be postponed.</li> </ul>
<p><b>Unlicensed assistive personnel (nurse aide, certified nursing assistant, CNA or other titles of non-nurses who assist in performing nursing tasks)</b></p>	<p><b>Example:</b></p> <ul style="list-style-type: none"> <li>■ At the beginning of the shift, the nurse instructed the nurse aide to ensure that the patient received hourly vital signs. The nurse did not check to ensure these were done and the patient had vital signs taken only once during the shift.</li> </ul>
<p><b>Patient</b></p>	<p><b>Example:</b></p> <ul style="list-style-type: none"> <li>■ An agitated patient was continuously scratching at his telemetry leads causing false V tach alarms. Nurse Rachel delayed checking the alarm and discovered the patient had an actual episode of V tach.</li> </ul>
<p><b>Patient's family/friend</b></p>	<p><b>Example:</b></p> <ul style="list-style-type: none"> <li>■ Nurse Patrick administered the patient his morning medications. It was not until later that morning that Nurse Patrick discovered the patient's wife had brought in his home medications and the patient had taken two doses of his antidepressant medication.</li> </ul>

## Healthcare Team Factors

21. Was there a healthcare team factor involved in the nursing practice breakdown?	
Intradepartmental conflict/ non-supportive environment	<p><b>Example:</b></p> <ul style="list-style-type: none"> <li>■ Staff were at odds over a new scheduling policy and the conflict carried over into inappropriate assignments of patient care.</li> </ul>
Breakdown of health care team communication	<p><b>Example:</b></p> <ul style="list-style-type: none"> <li>■ Oncoming nursing staff were not informed of a patient's revised advanced directives.</li> </ul>
Lack of multidisciplinary care planning	<p><b>Example:</b></p> <ul style="list-style-type: none"> <li>■ There was no attempt to coordinate a patient's discharge planning and teaching resulting in a non-ambulatory patient going home without support.</li> </ul>
Intimidating/ threatening behavior	<p><b>Examples:</b></p> <ul style="list-style-type: none"> <li>■ The medical director threatened a nurse's job if she continued to demand better staffing for her unit.</li> <li>■ A respiratory therapist screamed at a graduate nurse. The nurse was so upset she failed to maintain sterile technique while performing trach care.</li> </ul>
Lack of patient involvement in plan of care	<p><b>Example:</b></p> <ul style="list-style-type: none"> <li>■ A fearful patient was not given a chance to express concerns, which resulted in inadequate care.</li> </ul>
Care impeded by policies or unwritten norms that restrict communication	<p><b>Examples:</b></p> <ul style="list-style-type: none"> <li>■ The nurse was instructed to always call the night supervisor before contacting the physician at night.</li> <li>■ Only team leaders hear shift-to-shift report, so other staff were not fully aware of concerns or special needs of their patients.</li> </ul>
Majority of staff had not worked together previously	<p><b>Example:</b></p> <ul style="list-style-type: none"> <li>■ A new cohort of graduate nurses began their first week on the unit at the same time as the new resident physicians began their rotation, leading to gaps in communication.</li> </ul>
Lack of patient education	<p><b>Example:</b></p> <ul style="list-style-type: none"> <li>■ A patient was not instructed on the correct use of medication resulting in the patient taking the wrong dose once discharged from the hospital.</li> </ul>
Lack of family/caregiver education	<p><b>Example:</b></p> <ul style="list-style-type: none"> <li>■ A patient was discharged before the family members were instructed on the use of oxygen equipment.</li> </ul>

### Remediation Topics Addressing Nursing Practice Breakdown<sup>6,7</sup>

When the Committee has determined that the nurse has demonstrated a deficit in knowledge, judgement, skills, professional responsibility or patient advocacy and the nursing practice breakdown is a minor incident that does not require a report to the Board, remedial activities should be developed by the facility.

The first step in developing a plan for remediation is to evaluate the nursing practice breakdown deficits in Section IV that were identified during the review process. The remediation plan should be focused on updating the nurse's knowledge of current nursing theory and clinical practice to ensure competency in those areas.

Additionally, the Committee may choose to review the following broad classifications of nursing practice breakdown, which were developed by the National Council of State Boards of Nursing [NCSBN], to further evaluate the precipitating cause of the nursing practice breakdown event.<sup>6</sup> These categories are interrelated and more than one may be selected.

#### 1. Was Attentiveness/Surveillance a factor in the nursing practice breakdown?

While on duty, the nurse monitors and "sees" what is happening with the patient and staff. The nurse is responsible for observing the patient's clinical condition; if the nurse has not observed a patient, then he/she cannot identify changes if they occurred and/or make knowledgeable discernments and decisions about the patient.

#### 2. Was Clinical Reasoning a factor in the nursing practice breakdown?

Nurses must correctly interpret patients' signs, symptoms, and responses to therapies. This includes an evaluation of the any changes in patient signs and symptoms, ensuring that patient care providers are notified, and adjusting patient care appropriately. Clinical reasoning includes titration of drugs and other therapies according to the nurse's assessment of patient responses.

#### 3. Was Interpretation of authorized provider's orders a factor in the nursing practice breakdown?

The nurse is responsible for interpreting authorized provider orders, and implementing appropriate orders.

#### 4. Was Professional Responsibility/Patient Advocacy a factor in the nursing practice breakdown?

The nurse must demonstrate professional responsibility and understand the nature of the nurse-patient relationship. 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.

#### 5. Was Prevention a factor in the nursing practice breakdown?

It is important that the nurse follows usual and customary measures to prevent risks, hazards or complications due to illness or hospitalization. These include fall precautions, preventing hazards of immobility, contractures, stasis pneumonia, etc.

#### 6. Was Intervention a factor in the nursing practice breakdown?

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

## APPENDIX C:

### Additional Resources

#### References

1. 22 Texas Administrative Code §217.11 Retrieved from [https://www.bon.texas.gov/rr\\_current/217-11.asp](https://www.bon.texas.gov/rr_current/217-11.asp)
2. 22 Texas Administrative Code §217.12 Retrieved from [https://www.bon.texas.gov/rr\\_current/217-12.asp](https://www.bon.texas.gov/rr_current/217-12.asp)
3. Nursing Practice Act, Texas Occupations Code §301.401 Retrieved from [https://www.bon.texas.gov/laws\\_and\\_rules\\_nursing\\_practice\\_act\\_2017.asp#\\_Toc498606536](https://www.bon.texas.gov/laws_and_rules_nursing_practice_act_2017.asp#_Toc498606536)
4. 22 Texas Administrative Code §217.19 Retrieved from [https://www.bon.texas.gov/rr\\_current/217-19.asp](https://www.bon.texas.gov/rr_current/217-19.asp)
5. 22 Texas Administrative Code §217.16 Retrieved from [https://www.bon.texas.gov/rr\\_current/217-16.asp](https://www.bon.texas.gov/rr_current/217-16.asp)
6. National Council of State Boards of Nursing. (2010). *Nursing Pathways for Patient Safety*. St. Louis: Mosby Elsevier.
7. 22 Texas Administrative Code Chapter 224/225. Retrieved from [https://www.bon.texas.gov/laws\\_and\\_rules\\_rules\\_and\\_regulations\\_current.asp](https://www.bon.texas.gov/laws_and_rules_rules_and_regulations_current.asp)
8. 22 Texas Administrative Code Chapter 222. Retrieved from [https://www.bon.texas.gov/laws\\_and\\_rules\\_rules\\_and\\_regulations\\_current.asp](https://www.bon.texas.gov/laws_and_rules_rules_and_regulations_current.asp)
9. National Council of State Boards of Nursing. *Taxonomy of Error Root Cause Analysis of Practice (TERCAP)<sup>®</sup>Instrument*.

#### [Nursing Practice Act:](#) [Texas Occupations Code](#)

- Sections 301.401-301.419 related to *Reporting Violations and Patient Care Concerns*
- Sections 303.001-303.012 related to *Nursing Peer Review*

## Additional Resources Continued

**[Board](#)**  
**[Rules: Texas](#)**  
**[Administrative](#)**  
**[Code \(Title](#)**  
**[22, Part 11,](#)**  
**[Chapter 217\)](#)**

- [§217.1](#), related to *Definitions*
- [§217.11](#), related to *Standards of Nursing Practice*
- [§217.12](#), related to *Unprofessional Conduct*
- [§217.16](#), related to *Minor Incidents*
- [§217.19](#), related to *Incident-Based Nursing Peer Review and Whistleblower Protections*
- [§217.20](#), related to *Safe Harbor Nursing Peer Review and Whistleblower Protections*
  
- If the incident-based nursing peer review is related to an APRN, then consider:
  - §§221.1 - 221.17, related to *Advanced Practice Registered Nurses*
- And if the APRN has Prescriptive Authority, then consider:
  - §§222.1 — 222.10, related to *Advanced Practice Registered Nurses with Prescriptive Authority*
  
- If the nursing peer review is related to the RN delegation of a task, then consider rules within the applicable delegation chapter:
  - §§224.1 — 224.11, related to *Delegation of Nursing Tasks by Registered Professional Nurses to Unlicensed Personnel for Clients with Acute Conditions or in Acute Care Environments* and/or
  - §§225.1 — 225.15 related to *RN Delegation to Unlicensed Personnel and Tasks Not Requiring Delegation in Independent Living Environments for Clients with Stable and Predictable Conditions*

**Nursing Peer Review**

- [Nursing Peer Review/Incident-Based and Safe Harbor](#)
- [Nursing Peer Review Frequently Asked Questions](#)

**Minor Incident**

- [Flow Chart for Determining if an Error is a Minor Incident](#)
- [Nurse Responsibilities when an Error Occurs](#)

## Additional Resources Continued

### Nursing Practice:

- [General Practice Information](#)
- [APRN Nursing Practice Information](#)
- [Board of Nursing Position Statements](#)
- **Scope:**
  - [Scope- Licensed Vocational Nurse Practice](#)
  - [Scope-Registered Nurse Practice](#)
  - [Decision Making Model for Determining Nursing Scope of Practice](#)
  - [Scope- Advanced Practice Registered Nurse](#)
- [Guidelines](#)
- [Delegation Resource Packet](#)
- **Frequently Asked Questions (FAQs):**
  - [Nursing Practice](#)
  - [Advance Practice Registered Nurse](#)
  - [Nursing Practice in Disaster Areas](#)
  - [Licensure](#)
  - [Discipline](#)
  - [Delegation](#)

### Nursing Practice Breakdown:

- [Taxonomy of Error Root Cause Analysis of Practice-responsibility TERCAP®](#)
- TERCAP Publications
  - Benner, P., Malloch, K., Sheets, V., Bitz, K., Emrich, L., Thomas, M., Bowen, K., Scott, K., Patterson, L., Schwed, K., & Farrell, M. (2006). TERCAP: Creating a national database on nursing errors. *Harvard Health Policy Review*, 7(1), 48-63.
  - Benner, P., Sheets, V., Uris, P., Malloch, K., Schwed, K., & Jamison, D. (2002). Individual, practice, and system causes of errors in nursing: A taxonomy. *Journal of Nursing Administration*, 32, 509-523.
  - Hudspeth, R. (2010). The importance of engaging with TERCAP: Taxonomy of error root cause analysis and practice-responsibility. *Nursing Administration Quarterly*. 34, 88-89. doi: 10.1097/NAQ.0b013e3181c95f01
  - National Council State Boards of Nursing. (2010). *Nursing Pathways for Patient Safety*. St Louis, MO: Mosby Elsevier. ISBN 978-0-323-06517-7
  - Thomas, M. (2011). *TERCAP report*. Presentation presented at NCSBN Annual Meeting, Indianapolis. Retrieved from: <https://studylib.net/doc/5209032/tercap-report---national-council-of-state-boards-of-nursing>
  - Zhong, E. & Thomas, M. (2012). Association between job history and practice error: An analysis of disciplinary cases. *Journal of Nursing Regulation*, 2(4), 16-18. doi: 10.1016/S2155-8256(15)30249-0
- Board of Nursing Quarterly Newsletter: TERCAP
  - National TERCAP
    - Texas Board of Nursing Collecting Information to Better Understand Nursing Errors
      - [July 2009](#) issue (page 4)
  - Texas TERCAP Pilot
    - Texas TERCAP® Pilot Program Set to Start in August - Peer Review Committee Participation Sought
      - [July 2012](#) issue (page1)



## Additional Resources

### Nursing Practice Breakdown:

- Update on Texas Taxonomy of Error Root Cause Analysis of Practice-responsibility (TERCAP) Pilot
  - [January 2015](#) issue (page 5)
- Texas TERCAP Pilot Project Update
  - [April 2016](#) issue (page1)
- Texas TERCAP Pilot Project Completed
  - [July 2017](#) issue (page1)

### Suggested Remediation Courses:

- Texas Board of Nursing
  - Online Course [Catalog](#)
  - Approved [Third-Party Courses](#)
- National Council of State Boards of Nursing
  - [Online Courses](#) (Learning Extension)
- Texas Health and Human Services
  - Online Course [Catalog](#) of Workshops for Assisted Living Facilities, Intermediate Care Facilities for Individuals with Intellectual Disabilities, and Nursing Facilities

With its recent release, the Board is evaluating the clarity and implementation of the N-PREP Resource into the nursing peer review process. If you have questions about nursing peer review or the use of the resource please email [NPREP@bon.texas.gov](mailto:NPREP@bon.texas.gov)

If you have feedback to provide the Board about efficacy of the resource please click on the following link to complete the survey, we welcome any comments you may have.

<https://www.surveymonkey.com/r/NPREPResourceFeedback>