



POTENTIAL VIOLATION REPORT

North Dakota Board of Nursing
SFN 51278 (09/14)

North Dakota Board of Nursing
919 S 7th Street, Suite 504
Bismarck, ND 58504-5881
Telephone: 701-328-9775
Fax: 701-328-9785
Email: compliance@ndbon.org

REPORT REGISTERED AGAINST

Name		Home Telephone Number
Address		Cell Phone Number
City	State	Zip Code
*Social Security Number	Date of Birth	RN/LPN/UAP License/Registry Number
<input type="checkbox"/> Advanced Practice RN <input type="checkbox"/> Registered Nurse <input type="checkbox"/> Licensed Practical Nurse <input type="checkbox"/> Unlicensed Assistive Person		

EMPLOYMENT INFORMATION

Place of Employment		Work Telephone Number
Address		Employment Dates (From and To)
City	State	Zip Code
As a result of the incident(s), what action has the employment facility taken?		<input type="checkbox"/> Retained Individual <input type="checkbox"/> Accepted Resignation <input type="checkbox"/> Accepted Resignation in Lieu of Termination <input type="checkbox"/> Terminated Individual
Were multiple patients involved? <i>**If "Yes", complete this form for the specific incident that triggered the report to the Board or for the patient who suffered the most serious harm.</i>		<input type="checkbox"/> Yes <input type="checkbox"/> No
Date(s) of incident	Time(s) of incident	
Has this individual been previously disciplined and/or counseled by your facility for practice issues? <i>**If "Yes", please provide copies of pertinent documents</i>		<input type="checkbox"/> Yes <input type="checkbox"/> No
Type of Shift:	<input type="checkbox"/> 8 hour <input type="checkbox"/> 10 hour <input type="checkbox"/> 12 hour <input type="checkbox"/> on-call <input type="checkbox"/> Other	Shift Start Time Shift End Time
Number of days licensee/registrant worked in a row at the time of incident		
Was licensee/registrant working in a temporary capacity (traveler, float, covering for another nurse)?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Type of assignment at the time of the incident		
<input type="checkbox"/> Direct Patient Care <input type="checkbox"/> Charge <input type="checkbox"/> Combination patient care/leadership <input type="checkbox"/> Team Leader <input type="checkbox"/> Nurse mgr/supervisor		
Number of assigned direct care patients at the time of the incident		
Number of staff responsible for supervising at the time of the incident		
Number of patients responsible for including direct care & supervising patients at the time of the incident		
What was the nurse to patient staffing ratio at the time of the incident?	Number of Nurses	Number of Patients

NURSE FACTORS

Identify nurse factors that contributed to the practice breakdown

- | | |
|--|---|
| <input type="checkbox"/> Nurse's language barriers | <input type="checkbox"/> Nurse's cognitive impairment |
| <input type="checkbox"/> Nurse's high work volume/stress | <input type="checkbox"/> Nurse's fatigue/lack of sleep |
| <input type="checkbox"/> Nurse's drug/alcohol impairment/substance abuse | <input type="checkbox"/> Nurse's functional ability deficit |
| <input type="checkbox"/> Nurse's inexperience(with clinical event, procedure or patient condition) | <input type="checkbox"/> No rest breaks/meal breaks |
| <input type="checkbox"/> Nurse's lack of orientation/training | <input type="checkbox"/> Nurse's overwhelming assignment(s) |
| <input type="checkbox"/> Nurse's lack of team support | <input type="checkbox"/> Nurse's mental health issues |
| <input type="checkbox"/> Nurse's conflict with team members | <input type="checkbox"/> Nurse's personal pain management |
| <input type="checkbox"/> Lack of adequate staff | <input type="checkbox"/> Other – please specify _____ |
| <input type="checkbox"/> None | |

PATIENT DEMOGRAPHICS

Were specific patient care issues identified? <i>** If "No", skip this section.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Were the patient's family/friends present at the time of incident?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Patient Gender <input type="checkbox"/> Female <input type="checkbox"/> Male	Patient Age
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Pertinent patient characteristics at the time of incident:

<input type="checkbox"/> Agitation/combativeness	<input type="checkbox"/> Inadequate coping/stress management
<input type="checkbox"/> Altered level of consciousness	<input type="checkbox"/> Insomnia
<input type="checkbox"/> Cognitive impairment	<input type="checkbox"/> Sensory deficits (hearing/vision/touch)
<input type="checkbox"/> Communication/language difficulty	<input type="checkbox"/> Pain
<input type="checkbox"/> Depression/anxiety	<input type="checkbox"/> None
<input type="checkbox"/> Incontinence	<input type="checkbox"/> Unknown

Patient's two primary diagnoses -	1.	2.
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What happened to the patient?

<input type="checkbox"/> Abuse/neglect	<input type="checkbox"/> Nosocomial (hospital acquired) infection
<input type="checkbox"/> Allergic/anaphylaxis/transfusion reaction	<input type="checkbox"/> Treatment error/omission
<input type="checkbox"/> Medication error	<input type="checkbox"/> Patient fell
<input type="checkbox"/> Equipment failure	<input type="checkbox"/> Suicide
<input type="checkbox"/> Homicide	<input type="checkbox"/> Other – please specify _____
<input type="checkbox"/> Unknown	

Patient outcome as a result of incident

<input type="checkbox"/> No Harm – An error occurred but with no harm to the patient
<input type="checkbox"/> Harm – An error occurred which caused a minor negative change in the patient's condition
<input type="checkbox"/> Significant Harm – Involves serious physical or psychological injury, specifically including loss of function or limb
<input type="checkbox"/> Patient Death – An error occurred that may have contributed to or resulted in patient death

HEALTHCARE TEAM

Select other health care team areas that were involved in the incident:

- | | | |
|--|--|--------------------------------------|
| <input type="checkbox"/> Supervisory nurse/personnel | <input type="checkbox"/> Floating/temporary staff | <input type="checkbox"/> Patient |
| <input type="checkbox"/> Physician | <input type="checkbox"/> Other health care professional (PT,OT,RT) | <input type="checkbox"/> Pharmacist |
| <input type="checkbox"/> Other prescribing provider | <input type="checkbox"/> Patient's family/friends | <input type="checkbox"/> Staff nurse |
| <input type="checkbox"/> Health profession student | <input type="checkbox"/> Medication Assistant | <input type="checkbox"/> None |
| <input type="checkbox"/> Nurse aide / UAP/CNA | <input type="checkbox"/> Other support staff | |

Identify factors related to the health care team that may have contributed to the incident:

<input type="checkbox"/> Breakdown of health care team communication	<input type="checkbox"/> Lack of multidisciplinary care planning
<input type="checkbox"/> Care impeded by policies or unwritten norms that restrict communication	<input type="checkbox"/> Lack of patient involvement in plan of care
<input type="checkbox"/> Lack of patient education	<input type="checkbox"/> Majority of staff had not worked together previously
<input type="checkbox"/> Illegible handwriting	<input type="checkbox"/> Intradepartmental conflict/non-supportive environment
<input type="checkbox"/> Intimidating/threatening behavior	<input type="checkbox"/> None
<input type="checkbox"/> Lack of family/caregiver education	

SYSTEM ENVIRONMENT

Community Population	<input type="checkbox"/> Less than 10,000 <input type="checkbox"/> 10,000 to 50,000 <input type="checkbox"/> Greater than 50,000	Number of beds in facility
Type of facility:		
<input type="checkbox"/> Ambulatory Care <input type="checkbox"/> Critical Access Hospital <input type="checkbox"/> Long Term Care	<input type="checkbox"/> Assisted Living <input type="checkbox"/> Home Care <input type="checkbox"/> Office-based Surgery	<input type="checkbox"/> Behavioral Health <input type="checkbox"/> Hospital <input type="checkbox"/> Clinic
Type of medical record system:		
<input type="checkbox"/> Electronic Documentation <input type="checkbox"/> Electronic Medication Administration System <input type="checkbox"/> Combination Paper/Electronic Record	<input type="checkbox"/> Electronic Physician Orders <input type="checkbox"/> Paper Documentation	
Identify system elements that may have contributed to the incident - Check all that apply:		
<p>Communication Factors</p> <input type="checkbox"/> Communication systems equipment failure <input type="checkbox"/> Computer system failure <input type="checkbox"/> Interdepartmental communication breakdown/conflict <input type="checkbox"/> Lack of ongoing education/training <input type="checkbox"/> Lack of or inadequate orientation/training <input type="checkbox"/> Medical record not accessible <input type="checkbox"/> Patient identification failure <input type="checkbox"/> No adequate channels for resolving disagreements <input type="checkbox"/> Patient name similar/same <input type="checkbox"/> Patient Transfer (hand-offs) <input type="checkbox"/> Preprinted orders inappropriately used (other than medications) <input type="checkbox"/> Shift change (patient Hands-off) <input type="checkbox"/> None <input type="checkbox"/> Unknown	<p>Leadership/Management Factors</p> <input type="checkbox"/> Unclear scope and limits of authority/responsibility <input type="checkbox"/> Assignment or placement of inexperienced personnel <input type="checkbox"/> Inadequate patient classification (acuity) system to support appropriate staff assignments <input type="checkbox"/> Inadequate/outdated policies/procedures <input type="checkbox"/> Nurse shortage, sustained at institution level <input type="checkbox"/> Poor supervision/support by others <input type="checkbox"/> None <input type="checkbox"/> Unknown	<p>Environmental Factors</p> <input type="checkbox"/> Increased noise level <input type="checkbox"/> Code situation <input type="checkbox"/> Equipment failure <input type="checkbox"/> Frequent interruptions/distractions <input type="checkbox"/> Lack of adequate supplies/equipment <input type="checkbox"/> Multiple emergency situations <input type="checkbox"/> Physical hazards <input type="checkbox"/> Poor lighting <input type="checkbox"/> Similar/misleading labels (other than medications) <input type="checkbox"/> None <input type="checkbox"/> Unknown
<p>Backup and Support Factors</p> <input type="checkbox"/> Ineffective system for provider coverage <input type="checkbox"/> Lack of adequate provider response <input type="checkbox"/> Lack of nursing expertise system for support <input type="checkbox"/> Forced choice in critical circumstances <input type="checkbox"/> Lack of adequate response by other depts. <input type="checkbox"/> None <input type="checkbox"/> Unknown		
Identify any staffing issues that may have contributed to the incident – check all that apply:		
<input type="checkbox"/> Lack of supervisory/mgmt support <input type="checkbox"/> Lack of experienced nurses <input type="checkbox"/> Lack of clerical support <input type="checkbox"/> None	<input type="checkbox"/> Lack of other health care team support <input type="checkbox"/> Lack of nursing support staff <input type="checkbox"/> Other – please specify _____	

**PRACTICE BREAKDOWN CATEGORIES. Identify which of the following were a factor in the Practice Breakdown.
(Check all that apply)**

- Medication Error
 - Wrong Dosage
 - Wrong Patient
 - Wrong Route
 - Wrong Administration Technique
 - Wrong Time
 - Wrong Medication
 - Wrong Reason
 - Omission
 - Extra Dose
 - Unauthorized Medication
 - Mislabeled
 - Other – *provide explanation*

- Documentation Error
 - Pre-charting/untimely charting
 - Incomplete or lack of charting
 - Charting incorrect information
 - Charting on wrong patient record
 - Other – *provide explanation*

- Attentiveness/Surveillance
 - Patient not observed for an unsafe period of time
 - Staff performance not observed for an unsafe period of time

- Clinical Reasoning
 - Clinical implications of patient signs, symptoms and/or response to interventions not recognized
 - Clinical implications of patient signs, symptoms and/or interventions misinterpreted
 - Following orders, routine (rote system) without considering specific patient condition
 - Poor judgment in delegation and the supervision of other staff members
 - Inappropriate acceptance of assignment or accepting a delegated action beyond the nurse's knowledge and skills
 - Lack of knowledge

- Prevention
 - Preventive measure for patient well-being not taken
 - Breach of infection precautions
 - Did not conduct safety checks prior to use of equipment

- Intervention
 - Did not intervene for patient
 - Did not provide timely intervention
 - Did not provide skillful intervention
 - Intervened on wrong patient

- Interpretation of Authorized Provider's Orders
 - Did not follow standard protocol/order
 - Unauthorized intervention
 - Misinterpreted telephone or verbal order
 - Missed authorized provider's order
 - Misinterpreted authorized provider handwriting
 - Undetected authorized provider error resulting in execution of inappropriate order

- Professional Responsibility/Patient Advocacy
 - Nurse fails to advocate for patient safety and clinical stability
 - Nurse did not recognize limits of own knowledge and experience
 - Nurse does not refer patient to additional services as needed
 - Specific patient requests or concerns unattended
 - Lack of respect for patient/family concerns and dignity
 - Patient abandonment
 - Boundary crossings/violations
 - Breach of confidentiality
 - Nurse attributes responsibility to others

STATEMENT OF ALLEGED NURSE PRACTICES ACT VIOLATION(S)

1. Provide a brief statement describing the alleged practice breakdown and the implications of the incident to the health, safety, and welfare.

AND

2. Attach a detailed sequential description of relevant facts related to alleged behavior (who, what, where, when, why, how).

Identify whether the incident involved intentional misconduct or criminal behavior

- | | |
|--|--|
| <input type="checkbox"/> Changed/falsified charting | <input type="checkbox"/> Theft (includes diversion) |
| <input type="checkbox"/> Deliberately cover up error | <input type="checkbox"/> Criminal offense |
| <input type="checkbox"/> Fraud/misrepresentation | <input type="checkbox"/> Patient abuse (verbal, physical, emotional, sexual) |

CHECKLIST OF ACCOMPANYING DOCUMENTS – PROVIDE COPIES OF PERTINENT DOCUMENTS

Examples of documents that may be included are:

<ul style="list-style-type: none"> • Application for employment • Contracts • Counseling or prior disciplinary records • Employee performance evaluations • Facility policies and procedures related to the alleged incident 	<ul style="list-style-type: none"> • Incident reports • Internal investigation documents • Medication and narcotic records • Photographs • Patient records • Personnel records 	<ul style="list-style-type: none"> • Position descriptions • Pharmacy records • Staffing schedules • Statements of other persons involved • Termination notice
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LIST OF WITNESSES (Use additional paper if necessary)

Names of Contact	Home Address	Home Telephone Number/ Cell Number

PERSON REGISTERING REPORT

Name		Title	
Place of Employment (if applicable)			Telephone Number
Address	City	State	Zip Code
Signature			Date

The person named in the allegation may be given a copy of the Potential Violation Report. The Potential Violation Report and any accompanying documents may be an open or public record under NDCC 44-04-18.

*In compliance with the Federal Privacy Act of 1974, the disclosure of the individual's social security number on this form is mandatory pursuant to North Dakota Century Code 43-50-02. The individual's social security number is used for identification purposes.