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Safety Event Reporting

1. Purpose

The purpose of this plan is to provide guidance to faculty and leadership in nursing programs regarding errors/safety events/near misses made by students, faculty, preceptors or staff nurse working with student in clinical setting, simulation and lab. The plan is developed in accordance with state guidelines, specifically [WAC 246-840-513](#) and [WAC 246-840-519](#)

2. Scope

This plan outlines the responsibilities and procedures to be followed if a nursing student and/or faculty member is involved in an incident that the faculty has reason to believe resulted in a near miss or an occurrence that resulted in patient harm, an unreasonable risk of patient harm, or diversion of drugs or controlled substances.

3. Responsibilities and Procedures


In the event of an error or near-miss:

Student:

- Ensures the patient is safe
- Notifies the clinical faculty and the nurse responsible for the patient immediately

Bellevue College Clinical Faculty:

- Ensures the safety of the patient and student and takes appropriate immediate action in collaboration with the facility RN responsible for the patient
- Notifies the appropriate nursing leadership at the clinical facility of the event
- Ensures appropriate documentation is completed at the clinical site
- Completes the student/visitor or employee accident injury form: [File a Report :: Public Safety \(bellevuecollege.edu\)](#) (If the event occurred on Bellevue College Campus)
- Notifies the Course Coordinator immediately
- Completes [Bellevue College Nursing Adverse Health Events and Incident Reporting System Survey](#) IMMEDIATELY at the time of the event
- Completes [Root Cause Analysis](#) Survey, linked [here](#) within seven days of event occurrence
- Access [NCSBN Safe Study Resources](#) and [Student Error Debriefing Template](#)
- Upon completion of Bellevue College Nursing Adverse Health Events and Incident Reporting System Survey, notifies the BC Program Chair and the Associate Dean of Nursing of the event
- Notifies the BC Program Chair and the Associate Dean of Nursing of the event, upon completion of the Root Cause Analysis Survey

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Associate Dean of Nursing:

- Submits [WA DOH Incident Reports](#) (within 2 business days) to WABONEducationUnit@doh.wa.gov, in accordance with WAC guidelines
- Completes [Incident Event Log](#)
- Oversees the subsequent discussions and follow-up actions
- Updates faculty at Program Meeting if any near miss or safety events occurred
- Submits Root Cause Analysis Summary within 45 days of event to ncqac.education@doh.wa.gov
- If the incident presents an immediate safety concern to patient, students, healthcare team, or faculty, an emergency meeting is held for debrief.

Curriculum Chair:

- Debrief of root cause analysis findings reported on Bellevue College Nursing Adverse Health Events and Incident Reporting System Survey and evaluates trends and curriculum quality improvement at a curriculum meeting following the [Adverse Event Reporting Program Guide](#)

Definitions

Near miss:(1) A situation in which an event or omission, or a sequence of events or omissions, arising during clinical care fails to develop further, whether or not the result of compensating action, thus preventing injury to a patient. (NHS); (2) An event or situation that could have resulted in an accident, injury or illness, but did not, either by chance or through timely intervention. (QuIC)
<http://www.npsf.org/?page=dictionary&hhSearchTerms=%22definition+and+near-miss+and+event%22> Retrieved from National patient Safety Foundation Patient Safety Dictionary (2018).

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