

Board of Registration in Nursing – Medical Error Reduction in Nursing Facilities Grant

The Office of Program Development is assisting the UMass Center for Health Policy and Research (CHPR) on a grant collaboration with the Massachusetts Board of Registration in Nursing (BRN).

The grant proposal was submitted and approved by the National Council of State Board of Nursing (NCSBN). This two year grant funded the implementation of Phase I of a two-phase patient safety initiative to design, pilot and evaluate a non punitive, facility-based alternative to BRN's complaint resolution process on certain types of medication errors and to promote safe medication administration by nurses practicing in Massachusetts nursing homes.

The Office of Program Development was instrumental during the grant development as well as for the implementation of the grant tasks. Our responsibilities include developing a project plan in conjunction with the BRN, tracking timelines, identifying funding opportunities, and overall management of the project.

The three major activities of Phase I included:

1. Conduct an environmental scan involving nurses practicing in randomly selected nursing homes in order to anonymously determine their perceptions of their facility's culture of safety and barriers to medication error reporting,
2. Create a high quality sustainable strategic alliance of state regulatory agencies, directors of nursing and industry stakeholders,
3. Develop and implement a systematic plan, using the environmental scan data, for the design, pilot implementation and evaluation of
 - a. a "culture of safety" for curriculum to delivery to directors of nursing and others in nursing service leadership within participating nursing homes;
 - b. an education-oriented Nurse-Employer Safety Partnership (NESP) model which will assign responsibility at the facility level for conduction of a root cause analysis of medication errors and near misses that meet MBORN-approved criteria, and implementation of a corrective action plan for practice remediation and system change;
 - c. an NESP "Safety Culture Tool Kit for Reporting Medication Errors and near Misses" for use by Directors of Nursing and others in nursing service leadership within participating nursing homes; and
 - d. a multi-level learning network for lessons learned.

This ongoing work has resulted in a presentation to the Board of Nursing to present preliminary survey results and recommended criteria for medication error reporting. On January 13, 2010 the Board approved the recommended criteria.