

Agenda Item: 5.3.5  
Prepared by: M.B. Thomas  
Meeting Date: January 22, 23, 2009

## **Taxonomy of Error Root Cause Analysis of Practice – Responsibility TERCAP**

### **Summary of Request:**

This report provides a preliminary analysis of TERCAP demographic data from the Board's Enforcement Division.

### **Historical Perspective/Background Information:**

Texas is the most visible participant in the National Council of State Board of Nursing (NCSBN) efforts to capture information about nursing error. In a November 2008 report, the following information was shared about various state boards' participation in the project:

Texas	69 cases
North Carolina	31 cases
North Dakota	14 cases

Arizona, Kentucky, New Hampshire, New Mexico and Ohio are also participating in the project.

As of January 6, 2009, Texas has 100 cases in the data bank. Though the numbers are steadily increasing, NCSBN staff have advised the TERCAP committee that more numbers will be needed to conduct any type of relational analysis. Consequently, demographic information is being provided to gain a beginning understanding of nursing practice breakdown.

Attachment A provides demographic information about Texas 100 cases in the TERCAP data base.

### **Staff Recommendations:**

None. This report is for information only.

## Taxonomy of Error Root Cause Analysis of Practice (TERCAP) Texas 2008 Data (based on 100 cases submitted)

Figure 1: Patient Age

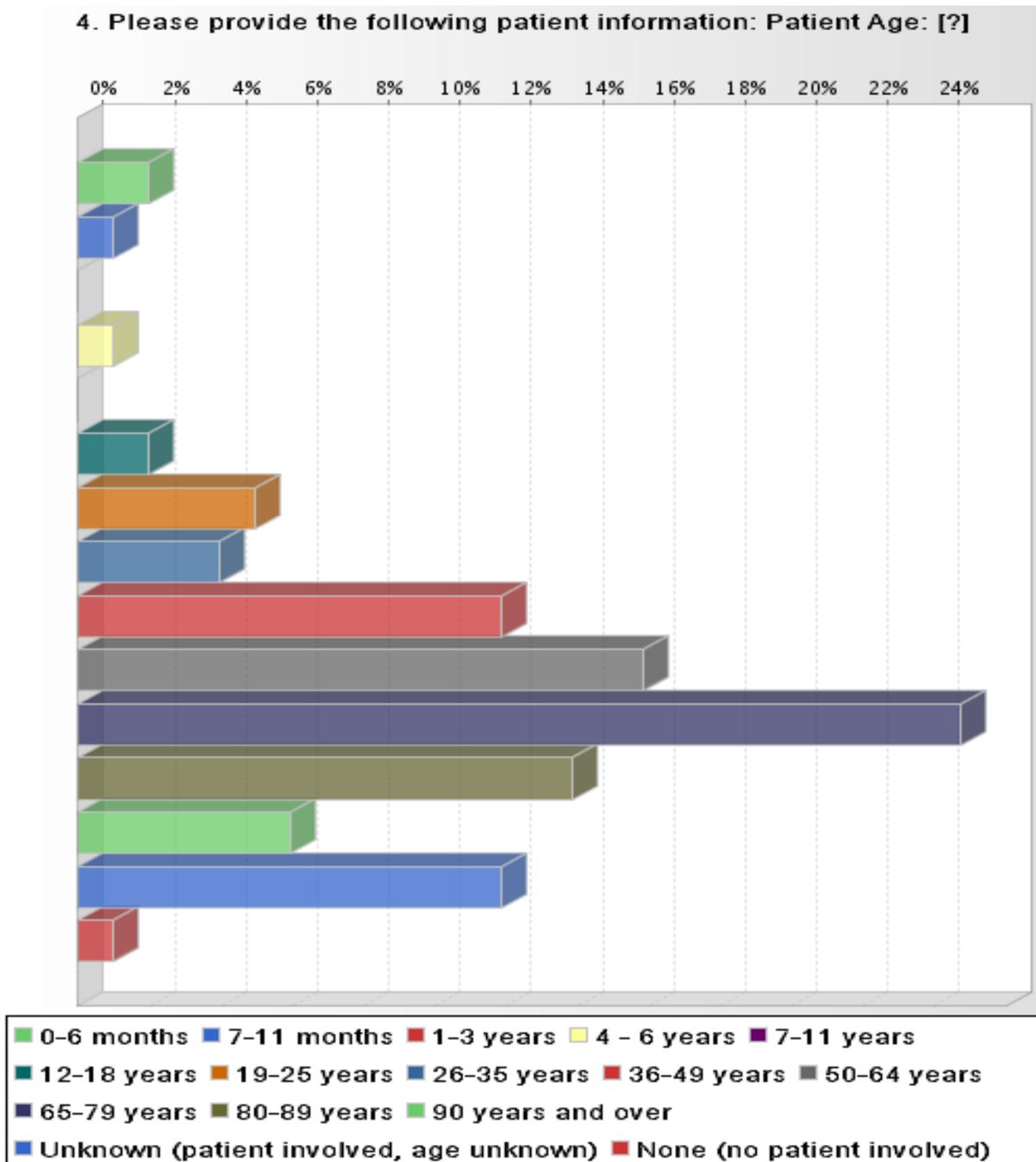


Figure 2: Patient Gender

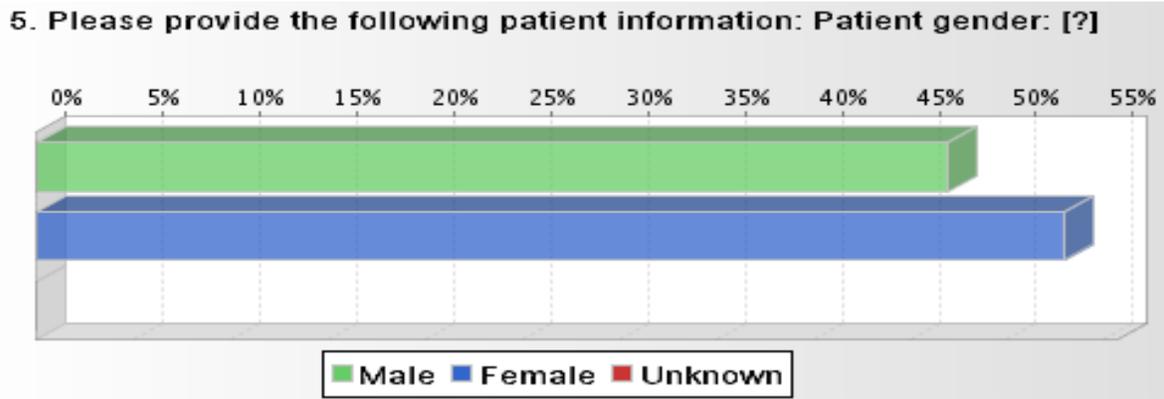


Figure 3: Patient Diagnosis

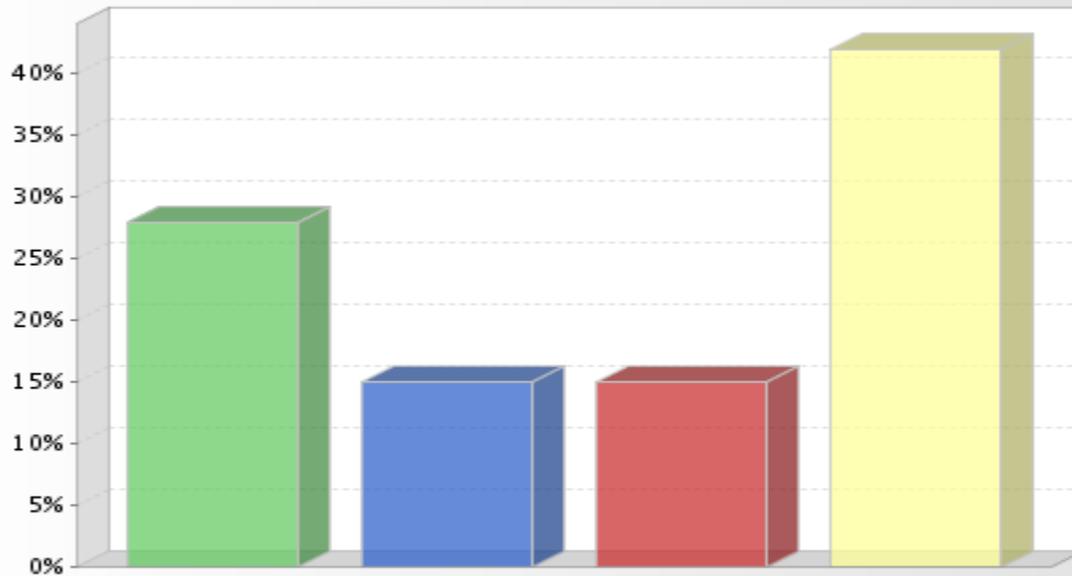
8. Indicate the patient's diagnosis, those that contributed to the reported situation.

Top 3:



Figure 4: Patient Harm

Harm is defined as temporary or permanent impairment of the physical, emotional or psychological function or structure of the body and / or pain that requires intervention. (National Coordinating Council for Medication Error Reporting and Prevention - NCC MERP) 10. Patient Harm [?]



- No harm - An error occurred but with no harm to the patient
- Harm - An error occurred which caused a minor negative change in patient health
- Significant harm - Significant harm involves serious physical or psychological injury
- Patient death - An error occurred that may have contributed to or caused patient death

Figure 5: Facility or Environment

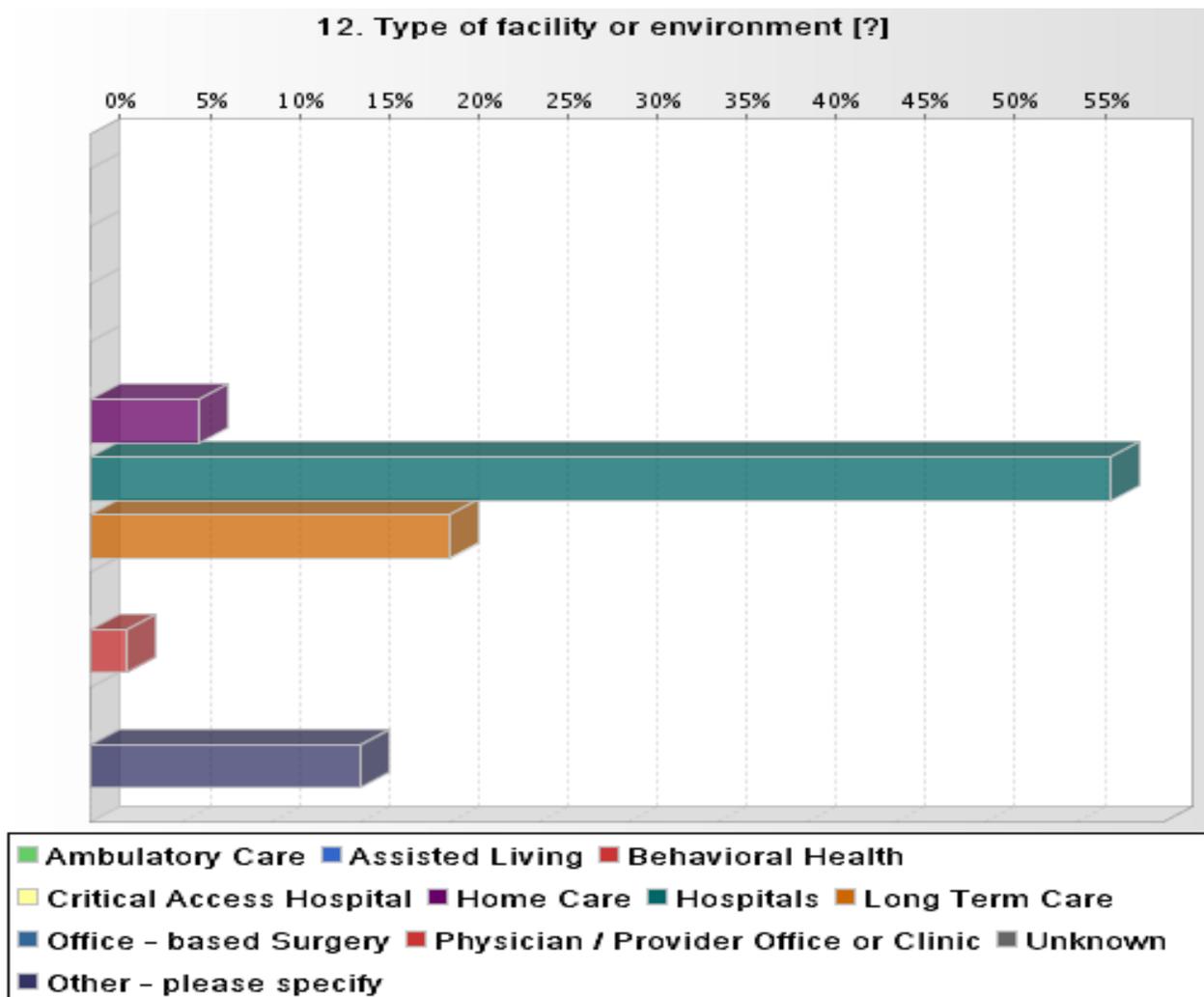


Figure 6: Health Team Members Involved in Practice Breakdown

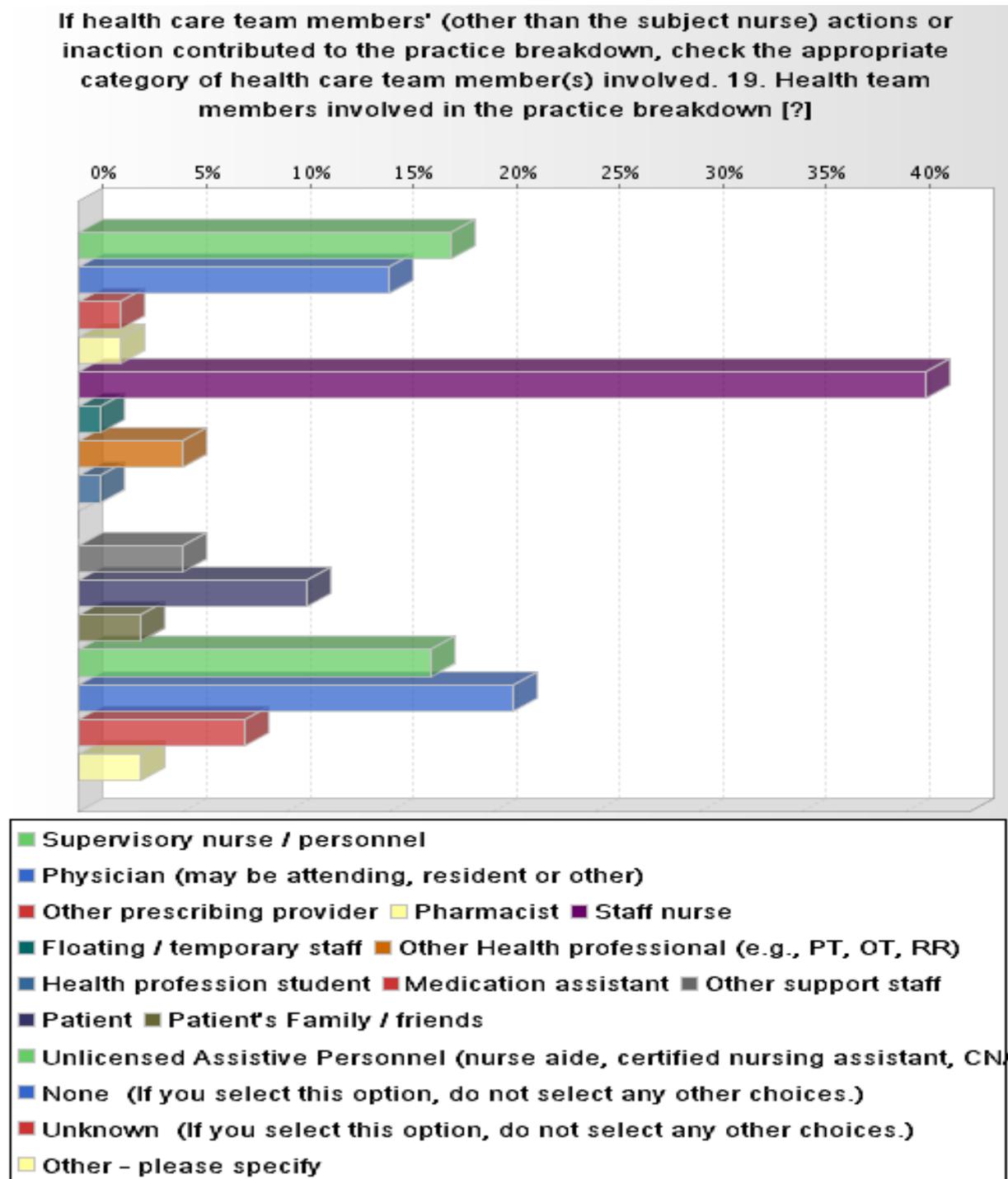


Figure 7: Current Licensure Status

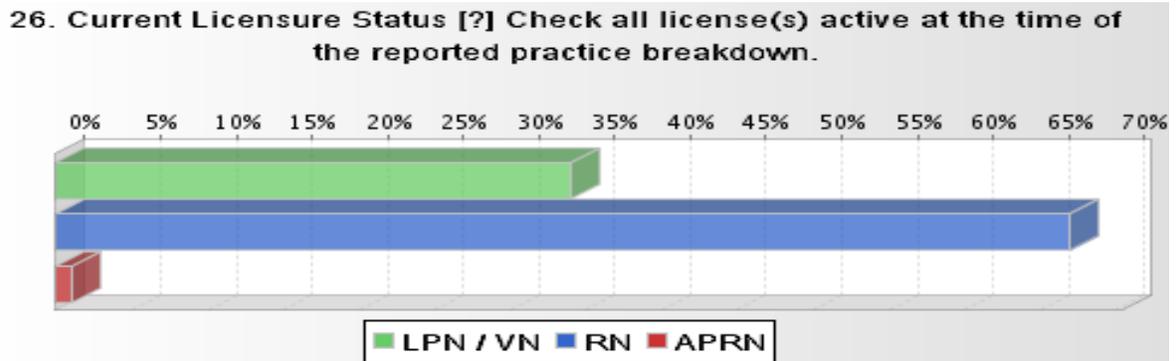


Figure 8: Nurse's Primary Language

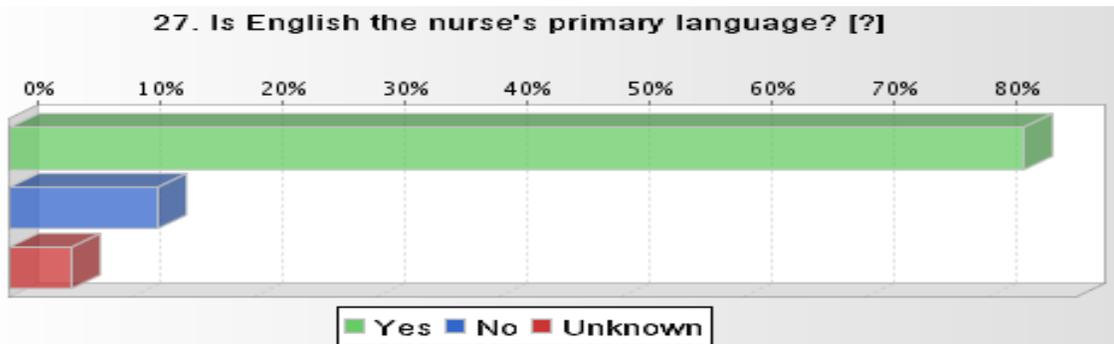


Figure 9: Length of Time Nurse Worked at Organization

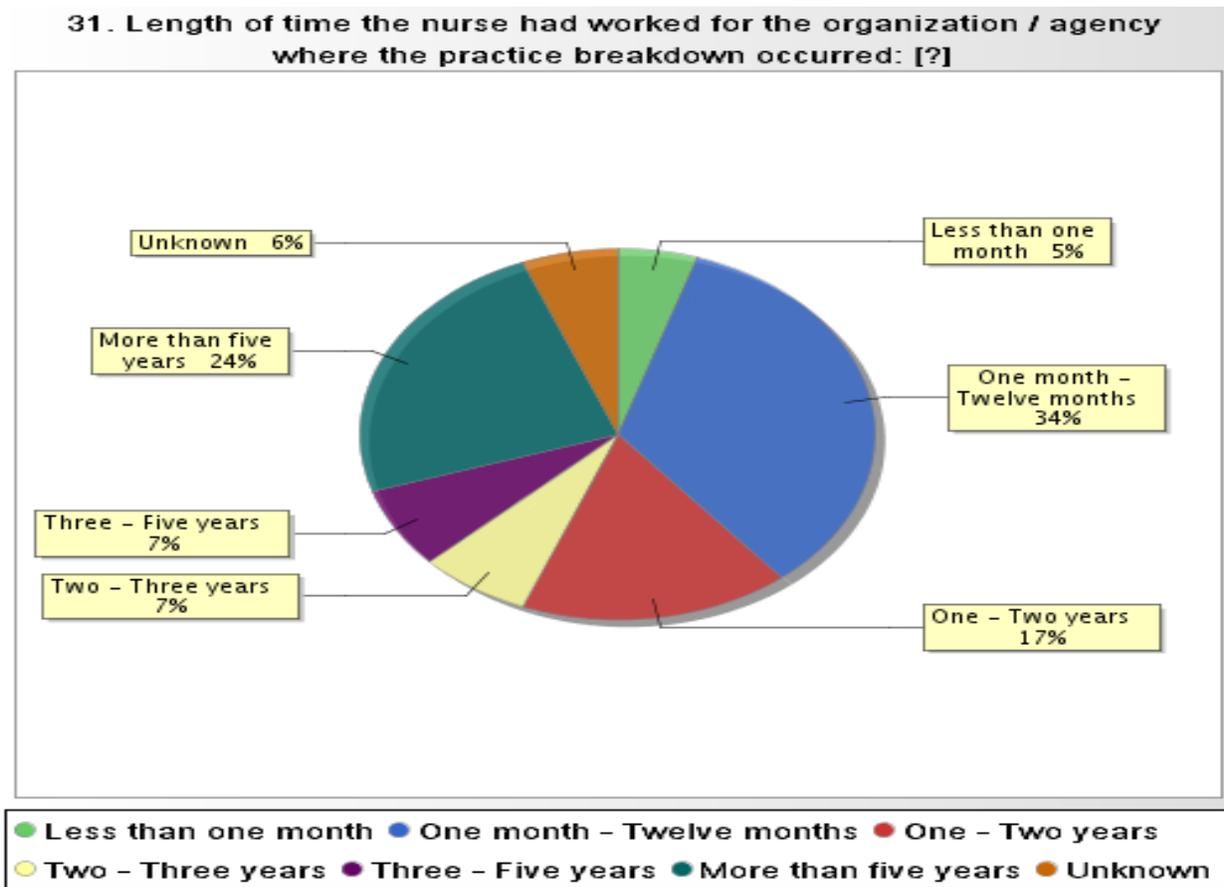


Figure 10: Assignment at Time of Practice Breakdown

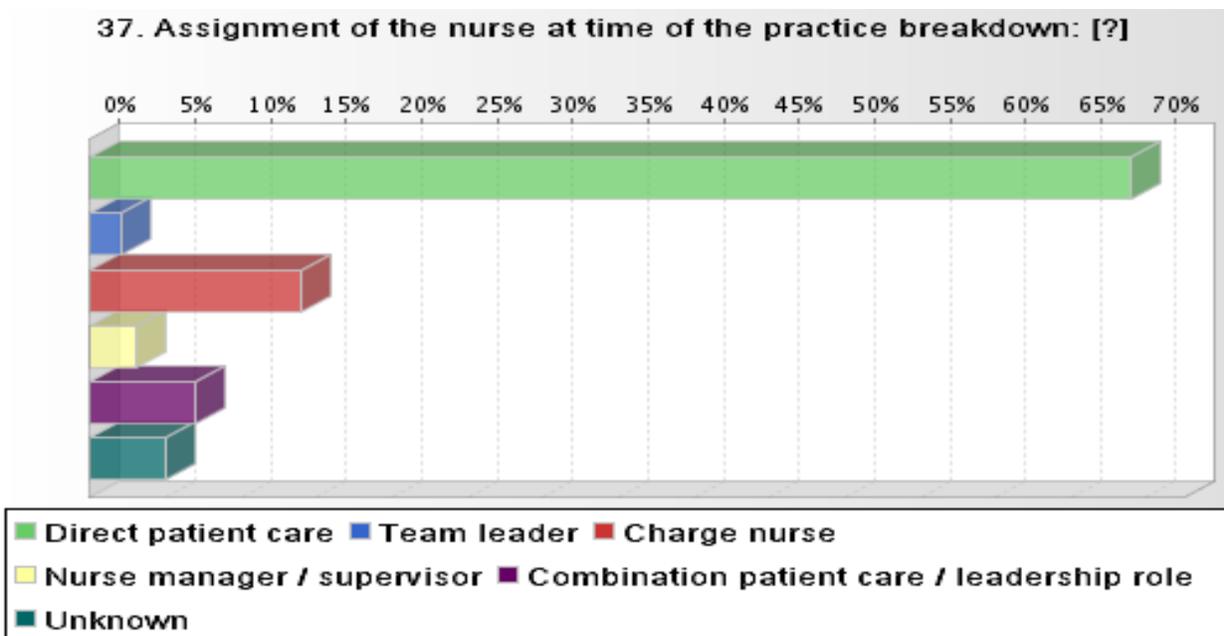


Figure 11: Previous Discipline History for Practice Issues

**43. Previous discipline history by employer(s), including current employer, for practice issues [?]**

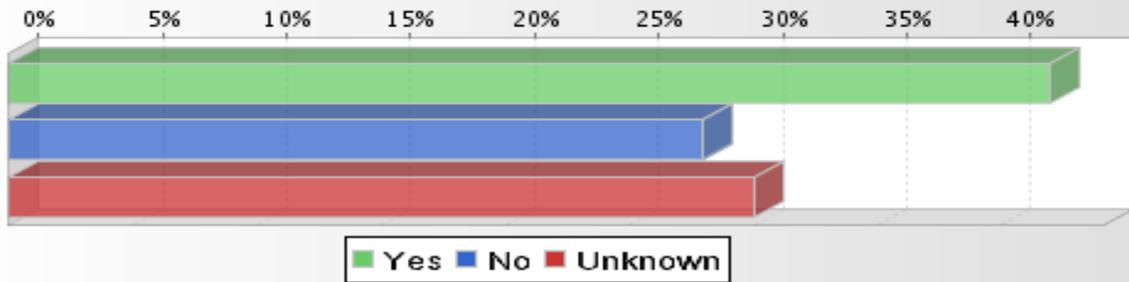


Figure 12: Terminated or Resigned from Previous Employment

**44. Terminated or resigned in lieu of termination from previous employment [?]**

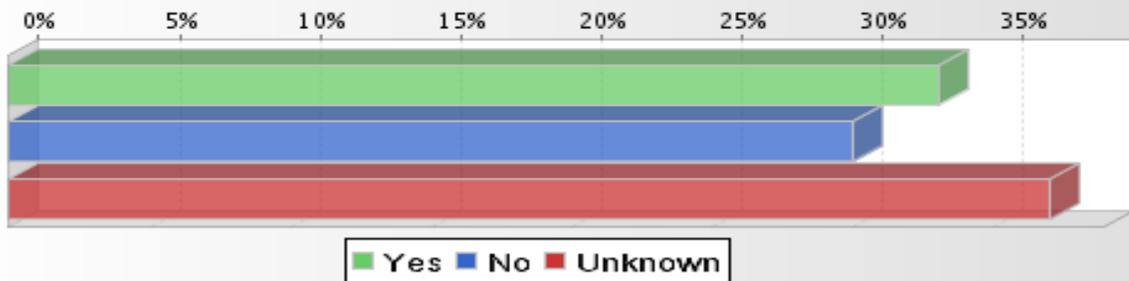


Figure 13: Previous Discipline by a BON

**45. Previous discipline by a board of nursing [?]**

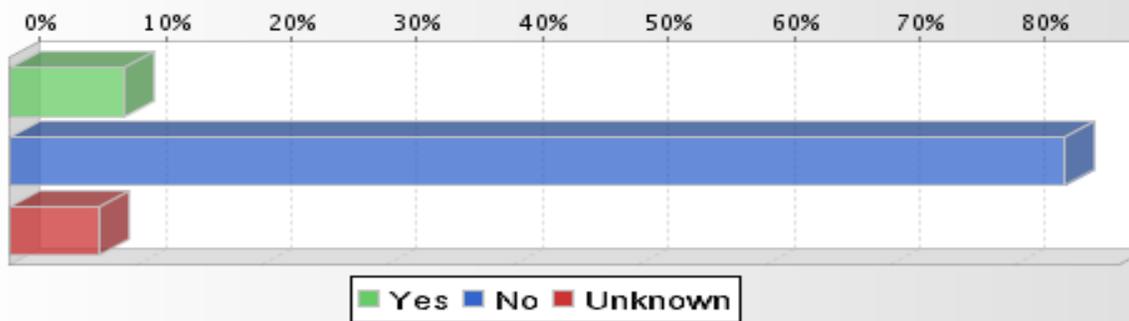


Figure 14: Employment Outcome

