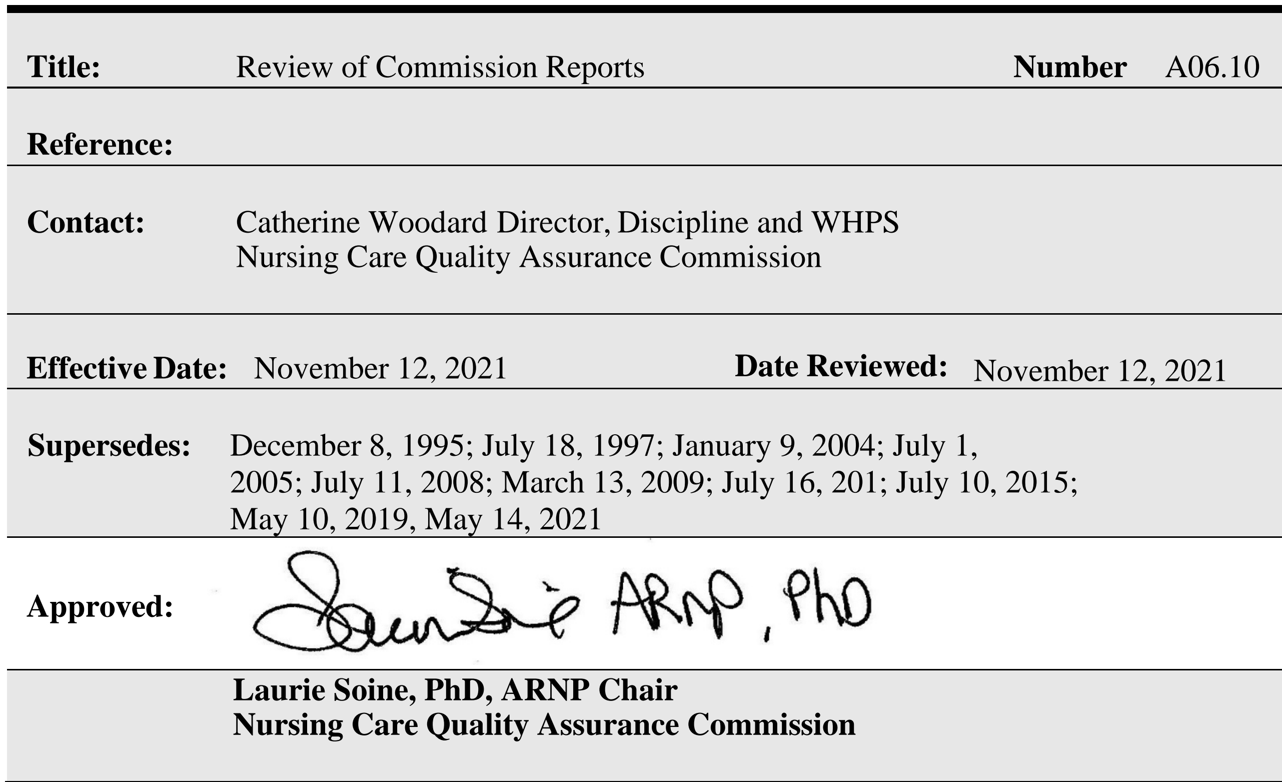
DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION
PROCEDURE



Title:	Review of Commission Reports	**Number**	A06.10
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Contact:	Catherine Woodard Director, Discipline and WHPS Nursing Care Quality Assurance Commission		
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Approved:	ARNP, PhD		
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PURPOSE:

This procedure clarifies and provides consistent review of reports to the Nursing Care Quality Assurance Commission (NCQAC) alleging harm, injury, misconduct, and crimes. This procedure assures a consistent response to allegations of practice violations that affect the health and safety of the public.

PROCEDURE:

The NCQAC uses a Case Management Team (CMT) to assess initial reports. Team members must include a panel of three NCQAC members (one of them a public member) with delegated decision-making authority, legal manager or designated staff attorney, chief investigator or designated investigator, and discipline case manager or designated staff member.

CMT determines if the report is within the NCQAC's statutory authority. When the NCQAC's authority is apparent, the CMT panel authorizes investigation of cases meeting the above-threshold criteria or closes cases that are below threshold. The CMT panel may also refer appropriate cases to the Early Remediation Program described in NCQAC Procedure A34.

The following lists are guidelines; any case may be opened based on case details. The CMT panel discusses and uses its own judgment to open or close the case.

OPEN FOR INVESTIGATION

1. Drug diversion
2. Impairment at work related to use or abuse of prescription or non-prescription drugs, or alcohol.
3. Substance use affecting ability to practice safely or narcotic use with impairment.
4. Sexual misconduct.
5. Practice error resulting in harm or unreasonable risk of harm.
6. Physical and verbal abuse.
7. Negligence that leads to patient death.
8. Mental incapacity or illness with harm to patient or likelihood of harm.
9. Gross misdemeanor or felony crimes.
10. Pattern of incompetence.
11. Beyond the scope of practice.
12. Practice with an expired license for more than 6 months.
13. Pattern of errors (three or more like instances over a 12-month period) *(Open all previouscomplaints that demonstrate a pattern of behavior.)*
14. Falsification of records including license applications.
15. Inappropriate delegation.
16. Negligent supervision resulting in an unreasonable risk of serious harm to a patient or resulting in serious harm to a patient.
17. Verbal threats to include physical harm and/or psychological harm.
18. Engaging in dissemination misinformation that may cause serious risk of harm.

CASES WHICH MAY BE APPROPRIATE FOR EARLY REMEDIATION (see Procedure A34)

1. Respondent "acknowledges" the practice error and seeks alternatives to avoid future errors. Does not require "admission."
2. Documentation errors that are careless, recurrent but do not rise to intentionally falsifying the record.
3. Communication breakdowns, such as errors in transcribing orders.
4. Failure to provide patient safety concerns at shift change.
5. Rude and non-therapeutic communication with patients and family members.
6. Substandard nursing practice.
7. Failure to properly conduct a patient assessment, document treatment, or administer medications.
8. Failure to comply with scope of practice requirements or delegation laws and regulations.

BELOW THRESHOLD

1. Any single occurrence reported with no harm to patient, nor prior pattern of complaints.
2. Single report of diversion of non-potential dependence producing drugs.
3. Reports where the facility documents corrective action and on-going monitoring of practice.
4. Misdemeanor crimes.
5. Falsification of employer documents not related to patient safety.
6. Violating confidentiality, e.g. HIPAA.
7. Reports of mental/emotional issues where no inappropriate conduct or behaviors in practice are present.
8. Inappropriate delegation to an unlicensed person that does not involve invasive procedures or piercing of skin (e.g., RN instructs nursing assistants to apply skin cream).

9. Practice with an expired license for six months or less.
10. Nursing error, which results in minor discomfort with no sequela, or a transient problem.
11. Failure to supervise resulting in no harm or minor harm to a patient.
12. Communication issues not involving verbal abuse or patient harm.
13. Demonstrated lack of credibility of the complainant.
14. Failure to report a change in patient status or to respond to change in a patient's condition resulting in no patient harm.
15. Isolated incident where negligence caused minimal harm to the patient, and the nurse accepted responsibility and obtained help, or the employer took corrective action.
16. Insufficient information provided.
17. Doesn't appear to be a violation of nursing law.
18. Lack of jurisdiction.
19. Termination of employment based solely on failing to meet the governor's vaccination mandate during a declared emergency with no practice involvement.

Below-threshold closures may include incidents with no harm or minimal harm.

If there are three or more below-threshold reports of similar actions within 12 months, all previous related reports that demonstrate a pattern of behavior should be re-opened and forwarded for investigation.

Approved 12/8/95
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Revised 7/1/05
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Revised 2/26/2019
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