The Adverse Event Decision Pathway (AEDP) was created in response to requests from nurse leaders and regulatory bodies for a tool to assist nurse leaders/administrators responsible for evaluation of adverse events and the regulatory reporting of unprofessional conduct or practice errors committed by nurses. This tool was developed in collaboration with nursing leaders from the National Council of State Boards of Nursing (NCSBN) and the American Organization for Nursing Leadership (AONL).

Following principles of the systems approach and just culture, the AEDP suggestions include a complete investigation of the adverse event, as well as the nurse's behavioral choices which may have contributed to any adverse event. The AEDP reflects a balance between justice and fairness on the one hand and the need to learn from a mistake and disciplinary action when appropriate on the other hand (Russell & Radtke, 2014).

The jurisdiction's regulatory body may also have specific requirements for special or mandatory reporting to the regulatory body. Information regarding reporting requirements is found in the individual laws and rules of the jurisdiction. Specific report format and process can be found on the juridiction's website.

DIRECTIONS

1. In partnership with the facility quality team, conduct an internal investigation on the adverse event occurrence.

2. With your data from the investigation, use the pathway starting with the question at the top, and progress to other questions based on affirmative or negative answers.

DEFINITIONS

Regulatory Body

Jurisdiction's governmental agency responsible for the regulation of nursing practice. Includes any other terminology to refer to the regulatory authority (i.e. board, commission, examiner, department or college)

Mitigating Factor

Were the actions of the nurse intended to deliberately harm the patient?

Were there circumstances involving the system which contributed to the adverse event/error?

Was the nurse terminated, suspended or resigned in lieu of termination?

Did the nurse fail to report the adverse event/error or falsify the records?

Is there a history or pattern

Were there significant mitigating factors that should be considered in the decision?