AN EVALUATION OF THE 1987 TEXAS SENATE BILL 1160: THE EFFECTIVENESS OF LEGISLATED ACCOUNTABILITY REQUIREMENTS FOR NURSES

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AN EVALUATION OF THE 1987 TEXAS SENATE BILL 1160:
THE EFFECTIVENESS OF LEGISLATED ACCOUNTABILITY
REQUIREMENTS FOR NURSES

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December 1990

The purpose of this study was to evaluate the effectiveness of Senate Bill 1160 in promoting accountability for professional nursing practice within the State of Texas. Mandatory reporting and peer review were examined as mechanisms to promote accountability. This study utilized a nonexperimental, explanatory evaluation research design. Data sources included record abstracts, interviews and responses to a questionnaire. Data analysis included the use of descriptive and inferential statistics.

Based on the findings of this study, it was concluded that professional nursing accountability was enhanced via the use of mandatory reporting and peer review as mandated by Senate Bill 1160. However, proportionally speaking in relation to the total RN population, under reporting of incompetent nurses was probably occuring. It was also concluded, that peer review was primarily being utilized as a reactive process and not in a proactive manner aimed at improving the overall quality of professional nursing practice.

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CHAPTER 1

INTRODUCTION

In recent years, there has been an increased awareness of quality assurance and accountability in the health care system. This increased interest can be attributed in part to a greater emphasis on quality assurance in reimbursement programs and in part to the identification of the incompetent practitioner as a factor contributing to the professional liability insurance crisis (TNA, 1989). Numerous laws and regulations have been formulated by government and regulatory agencies which focus on enhancing public accountability including Texas Senate Bill 1160 (1987).

During the Texas 1987 legislative session, political pressure was exerted on legislators by insurance companies for tort reform and enhanced accountability of the medical and nursing professions within the State of Texas. As a result, the 1987 Texas Legislature passed Senate Bill 1160, (SB 1160) entitled the "Registered Nurse Quality Assurance Bill."

SB 1160 was designed to improve the quality of nursing practice in the State of Texas, thereby improving the quality of care provided to consumers. Required mandatory reporting of unsafe practice to the licensing

board and establishment of peer review committees in all health care institutions employing ten or more registered nurses are the primary components of SB 1160. The legislative requirements contained within SB 1160 became effective on January 1, 1988.

The Problem of Study

This study will provide information related to the following research question:

How has Texas Senate Bill 1160 (1987) affected professional nursing accountability within the State of Texas?

Rationale for the Study

Maas, Specht, & Jacox (1975) described accountability as being answerable to society for the quality of professional practice. Quality of care is contingent upon professional accountability which is a social obligation and is often mandated of nurses by society, institutions, and professional groups (Passos, 1973; Matek, 1977; Lewis & Batey, 1982; ANA, 1983).

Research designed to examine programs or policies intended to promote quality in health care has been described as the stepping stone that provides direction for the actions necessary to improve care (Stivers, 1987). Numerous authors have spoken to the need for research

aimed at examining the effectiveness of quality assurance programs (Donabedian, 1980; Bliersbach, 1988; Driever, 1988; Smeltzer, 1988; Wilson, 1988).

In examining the effectiveness and efficiency of health policy, Mitsunaga (1981) found that most health policy is undertaken where little previous experience existed. Decisions are initially based upon social phenomena, intuition and past experiences of the policy makers. Therefore, research is necessary to evaluate the results of health policy on consumers and professionals by either estimating the parameters of policy-relevant phenomena, monitoring the phenomena, causal modeling, or policy/program evaluation (Mitsunaga, 1981). Numerous authors have stressed the need for nurses to participate in health policy research, based on knowledge that socioeconomic and environmental factors have a major impact on health status and outcomes (Diers, 1986; Merrill, Sass, & Somers, 1986; Solomon & Roe, 1986).

According to Cronbach (1983), a public policy or program is, in reality, a treatment method or operational plan or directive for rendering some service to society. There is a need to evaluate the effectiveness of such policies or programs to determine if the treatment method has been successful in achieving its goals (Suchman, 1967; Weiss, 1972; Poister, 1978; Cronbach, 1983; Rist, 1987).

Social institutions learn from experience as well as programs, clients, and political constituents. Therefore, the function of evaluation is to speed up the learning process by communicating what might otherwise be overlooked or wrongly perceived. Evaluative findings frequently have no direct effect on the program studied; however, broader consequences may result from indirect conceptual uses of the information (Cronbach, 1983).

The evaluative process examines the experience of the program and influences the direction of new policies or programs based on the original experience (Weiss, 1972; Cronbach, 1983). An evaluation would be particularly significant in relation to SB 1160 because the bill represents unique, pioneer legislation in promoting accountability for nurses in the United States (M. Kelly, Director of Public Policy Analysis, National Council of State Boards; personal communication, June, 22, 1989). Other states and professions may utilize the Texas model for guidance in establishing similar legislation.

Conceptual Framework

The purpose of this study is to evaluate the effectiveness of SB 1160 in promoting accountability for professional nursing practice within the state of Texas. The conceptual framework for this study will be based on the evaluation process as described by Suchman (1967) and Green's (1989) framework for accountability.

The Evaluation Process

Suchman (1967) described a conceptual framework for the evaluation process. Evaluation is defined as the determination of the results attained by some activity designed to accomplish some valued goal or objective. This definition contains four key dimensions: (1) process- the "determination"; (2) criteria - the "results"; (3) stimulus - the "activity"; and (4) value - the "objective" (Suchman, 1967, p. 32).

The determination may be based on numerous types of data. The results may be desirable or undesirable, transient or permanent, immediate or delayed. The activity may be a program or part of a program derived from a health policy. The accomplishment of the goal or objective may be ultimate, intermediate, or immediate; based on effort or performance; long or short range. The scientific method with its accompanying research techniques then provides the most promising means for determining the relationship of the stimulus to the objective in terms of measurable criteria.

The evaluation process is a circular one, stemming from and returning to the formation of values (Figure 1). Each aspect of the model will be described in detail.

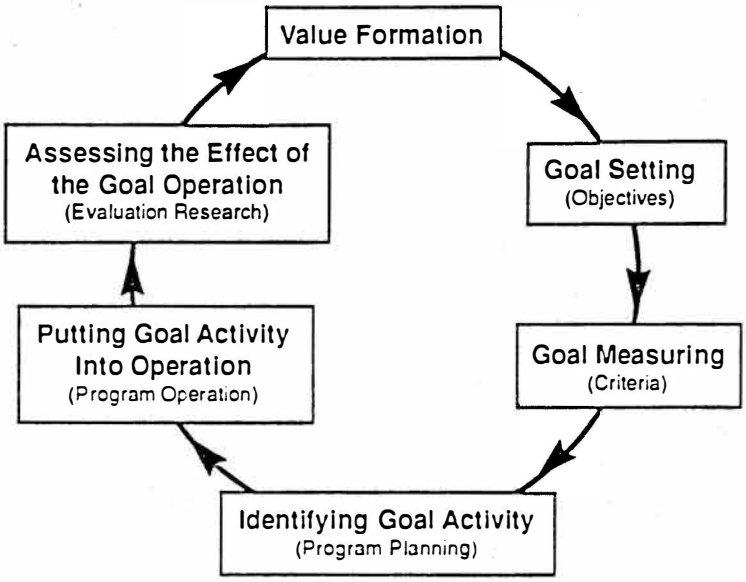

Figure 1. The Evaluation Process (Suchman, 1967)

Evaluation always starts with some value, either explicit or implicit; then a goal is formulated and derived from this value. The selection of goals is usually preceded by or concurrent with "value formation" (Suchman, 1967). An example of "goal setting" described by Suchman, would be the statement that fewer people should develop coronary artery disease, or that fewer people should die from cancer. Goal setting forces are always in competition with each other for money, resources, and effort (Suchman, 1967).

The next step in the evaluation process is determining some way of measuring goal attainment (Suchman, 1967). The nature of the evaluation will depend largely on the type of measures that are available to determine the attainment of the objectives. Criteria are formulated to measure goal attainment. There must then be an identification of some kind of goal-attaining activity which is subsequently placed into operation. Next there is the assessment of the goal-directed operation. This stage includes the evaluation of the degree to which the operating program has achieved the objectives.

Finally, on the basis of the assessment, a judgment is made as to whether the goal-directed activity was worthwhile. The end of the evaluation process may lead to a new value, or reaffirm, reassess, or redefine an old value. It is not necessary to begin at the value formation stage. Values may already be formed and goals already set. The sequence of operations in the process may be variable. The evaluator may come in at any point, as activites are usually already on going (Suchman, 1967).

Categories of Evaluation

Suchman (1967) described five categories of effectiveness upon which evaluation research may be conducted. These categories represent the various criteria for success or failure according to which a

program may be evaluated. They are applied to each objective and serve to define the type of measure to be used in judging an activity. The categories are : (1) effort, (2) performance, (3) adequacy of performance, (4) efficiency, and (5) process. A brief description of each category is provided in Table 1.

Table 1

Suchman's Categories of Evaluation

Category	Description	Measures
Effort	quantity & quality of activity	input regard-less of output
Performance	results of effort	output
Adequacy of Performance	adequacy in terms of objective	degree of effectiveness
Efficiency	ratio between effort & performance	costs vs benefits
Process	explanations	how & why program functions

Application of Suchman's Framework to SB 1160

The phases of the evaluation process will be briefly discussed as they relate to SB 1160. Figure 2 provides an illustration of SB 1160 in relation to the evaluation process.

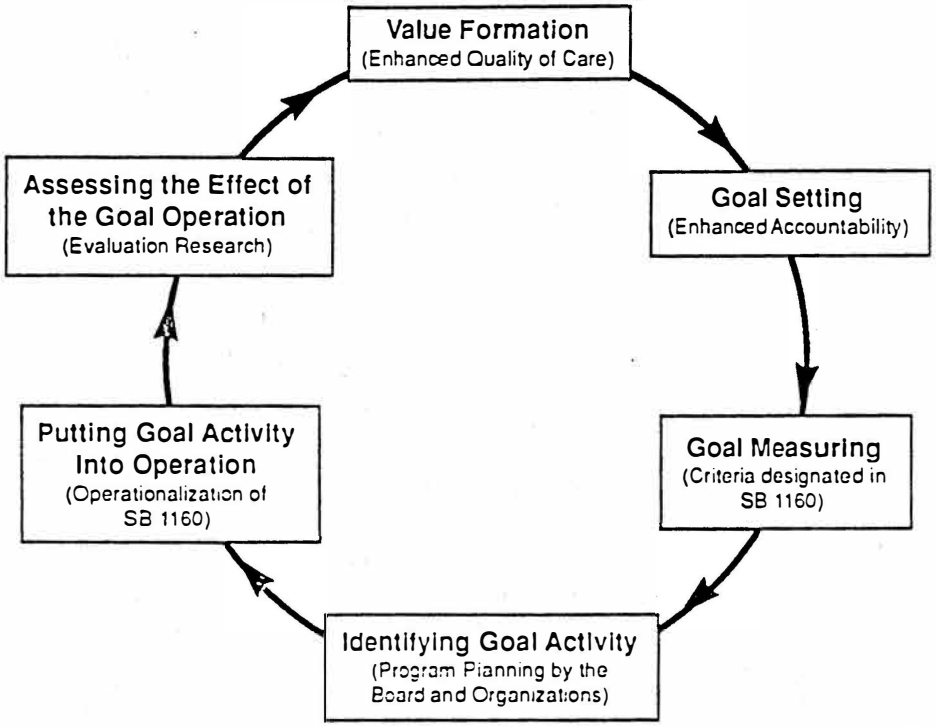

Figure 2. Application of SB 1160 to the Evaluation Process

Value Formation

The objectives of most service programs and health policies have many implicit beliefs buried in them. Suchman (1967) found that most objectives are built on inherent, conceived, and operational values. In this study, SB 1160 enacted interventions which were believed to promote accountability for professional nursing practice. The interventions (mandatory reporting and

peer review) establish the inherent value that enhanced accountability will lead to a higher quality of care delivered to consumers.

The conceived value for this policy can be stimulated by dramatizing the impact of incompentent practitioners providing care to consumers. Finally, an operational value is created in those nurses who participate in mandatory reporting and peer review, thereby leading to the removal of an incompentent nurse from the practice setting. A failure to use the process of mandatory reporting and peer review would suggest that nurses rejected the operational value of the policy because it clashed with other, more important values. For example, a nurse's value for privacy and self-determination may outweigh all other considerations.

Since evaluation always starts with some value, either explicit or implicit, identification of the underlying values is important. The explicit value inherent in SB 1160 is the provision of quality health care to consumers. Legislators could easily voice their position on the value of ensuring quality health care for all consumers. However, the implicit value involved in the passage of this legislation, could be identified in committee testimony and was that of insurance companies desiring to limit financial restitution stemming from liability suits involving

incompetent practitioners (Texas Senate Health & Human Services Committee, 1987).

Goal Setting

SB 1160 is an act "relating to the regulation of professional nursing, the establishment of professional nursing peer review, and certain professional nursing reporting procedures" (1987, p. 2263) which was intended to promote professional accountability. Enhancing accountability for the nursing profession then becomes the objective by which the value of quality care can be reinforced.

One of the first steps in evaluation research is determining the goals or objectives of a program or policy (Suchman, 1967; Weiss, 1972; Cronbach, 1983). The contents of Senate Bill 1160 fall into three main sections according to the Texas Nurses Association (1987). These sections are outlined and goals identified in Appendix A.

Goal Measuring

The criteria for enhancing professional nursing accountability were provided by the legislature within the content of SB 1160. The bill entails an indepth description of how accountability will be enhanced under this act; the bill is presented in Appendix B.

Identifying Goal Activity & Putting Goal Activity Into Operation

Authority and responsibility for program planning to enforce this act were delegated to the Texas State Board of Nurse Examiners (BNE). The legislature, through revision of the Nurse Practice Act, mandated the establishment of peer review committees in any setting where 10 or more registered nurses (either full-time or part time) are employed (BNE, 1989). The bill also requires mandatory reporting of registered nurses who practice below the current standards of nursing practice.

The Board was clearly provided a stronger disciplinary role in monitoring quality of nursing practice for consumers. However, the primary criteria outlined for goal achievement in the bill, include the decentralization of the accountability process to the local level. Every practicing professional nurse is required to report an incompetent practitioner and all institutions employing more than 10 professional nurses are required to establish peer review committees.

Assessing The Effect Of This Goal Operation

Program evaluation by the BNE was undertaken in 1989 to address whether the provisions of mandatory reporting and peer review in the Nurse Practice Act (as amended by SB 1160) had been implemented as intended (BNE, 1989). The BNE was primarily concerned with the implementation

of the bill and did not deal with the effectiveness of the bill in promoting accountability. The author assessed the effectiveness of SB 1160 via the evaluation research process, comparing nursing accountability prior to and after enactment of SB 1160.

A Conceptual Model for Accountability

The primary objective of SB 1160 was to enhance professional nursing accountability and thereby uphold the value of quality of care as illustrated by Suchman's framework for the evaluation process. Since the primary objective was the promotion of accountability, a conceptual framework for accountability, Green's Accountability Model (1989), assists in clarifying the relationship between the major constructs of health policy and quality of care, and the concepts of accountability, mandatory reporting, and peer review.

Green's Model of Accountability (1989) was derived through the use of concept synthesis and was based upon the earlier work of Matek (1977), Donabedian (1980), and Batey and Lewis (1982). The model utilizes the basic concepts of efficiency, effectiveness, and appropriateness which have evolved within the context of accountability (Green, 1989). Accountability is a state of being accountable, answerable, explainable, and liable, which can be expressed as the process of disclosure. Disclosure occurs so that decisions and evaluations can

be made regarding professional practice. Accountability is closely related to the other components of professional practice: autonomy, authority, and responsibility (Passos, 1973; Maas, Specht, & Jacox, 1975; Lewis & Batey, 1982; Batey & Lewis, 1982).

Donabedian (1988) described levels at which quality may be assessed. One level is the performance of practitioners and consists of two elements: the technical and the interpersonal. In health care, the expectations of performance are expressed within standards, policies, procedures, and codes of ethics. The quality of nursing practice is judged against standards which are tangible and therefore subject to measurement (Vengroski & Saarmann, 1978; ANA, 1983; Whittaker & McCanless, 1988). This judgement is mandated by society in assuring accountability for many professionals.

Interrelationships Among Similar Concepts

Accountability, authority, autonomy, and responsibility are interrelated concepts (Figure 3). Responsibility and authority are necessary conditions for both autonomy and accountability. It is illogical to hold an individual or group accountable for an activity for which they have no responsibility or authority. Autonomy is also a necessary condition for accountability. Accountability is an exercise in futility unless it is

linked to nursing autonomy (Lewis & Batey, 1982)

The principal consequences of autonomy and authority can be said to be responsibility and accountability. Responsibility can be described as the charge; authority is the rightful power to act on the charge; autonomy is the freedom to decide and to act; and accountability is the disclosure regarding the charge (Lewis & Batey, 1982). All four concepts are key elements of professional nursing practice (Passos, 1973; Maas, Specht, & Jacox, 1975; Lewis & Batey, 1982; Batey & Lewis, 1982).

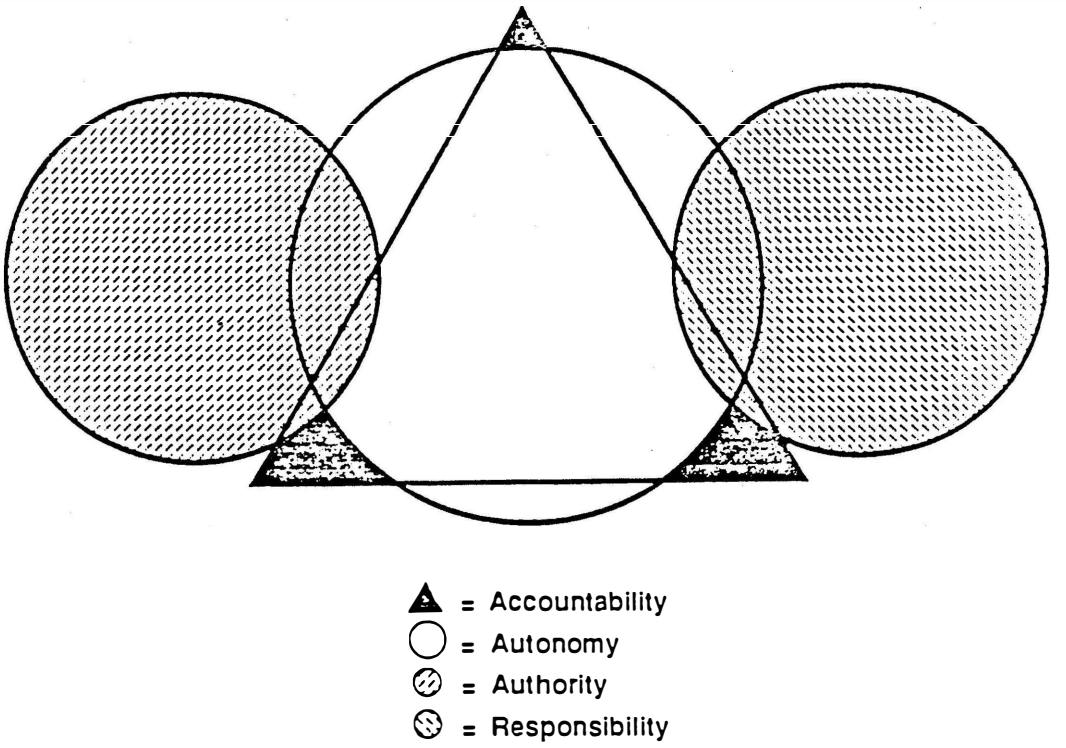

Figure 3. The Relationship Between Accountability, Autonomy, Authority, and Responsibility

In summary, Green (1989) derived the following statements concerning accountability:

> Accountability is a process which serves a social function and is often mandated by the government; accountability involves disclosure of efficiency, effectiveness, and appropriateness of professional nursing practice; decisions and evaluations intended to improve the quality of professional nursing practice are derived from the information disclosed; and accountability can imply social liability when disclosure reveals inefficient, ineffective, or inappropriate nursing practice. (p. 18)

Peer Review

Peer review is considered part of the nursing professions' quality assurance responsibilities (ANA, 1988). Society grants the professions authority over functions vital to itself, and permits its members considerable autonomy in the practice of their own profession. In turn, the professionals are expected to act responsibly and to demonstrate accountability. The authentic hallmark of a mature profession is self-regulation to ensure quality in performance (Donabedian, 1980).

In the nursing profession, self-regulation is based upon a code of ethics and standards of practice that provide guidelines for the carrying out of nursing responsibilities in a manner consistent with the ethical obligations of the profession and with quality in nursing practice (ANA, 1976). Nurses are functioning with increased autonomy, and making more decisions for

which they are held accountable. Peer review has emerged as the responsible and progressive way to monitor the quality of care and to assure professional accountability (Whittaker & McCanless, 1988).

Peer review in nursing is the process by which registered nurses actively engage in the practice of nursing, systematically assess, monitor, and make judgments about the quality of nursing care provided to clients by other peers as measured against established standards of practice (ANA, 1988). Consistent with the goal of quality, peer review activities are focused on the practice decisions of professional nurses to determine the appropriateness and timeliness of those decisions. The services provided as a result of practice decisions are reviewed to determine their necessity, effectiveness, and efficiency (ANA, 1988).

Relational Statements

Relational statements describe some type of relationship among the concepts within them (Walker & Avante, 1983) and serve as the skeleton of a conceptual framework. The relationship between the construct of health policy (SB 1160) and quality of care (value) and the concepts of peer review/mandatory reporting and accountability (goals) will be examined using correlational statements. The following concurrent relational statements were derived:

1. Nurses are accountable to society for the quality of nursing practice as designated by health policy (SB 1160);

2. And if the accountability "process" via the "activities" of mandatory reporting and peer review "results" in enhanced quality of nursing practice;

3. Then the "value" of enhanced quality of care will be achieved.

Assumptions

1. Consumers and health care professionals (nurses) function within a social system (Matek, 1977; Donabedian, 1980; King, 1981).
2. Social systems via health policy influence nursing practice and accountability (Matek, 1977; Milio, 1983; Solomon & Roe, 1986).
3. The goal of nursing is to help individuals maintain health and avoid illness (King, 1981); nursing care affects the outcome of the patients' illness and influences their future health status.
4. Quality of care is contingent upon professional accountability, which is a social obligation and is often mandated of nurses by society, institutions, and professional groups (Donabedian, 1980; Lewis & Batey, 1982; ANA, 1983).
5. Peer review is part of the nursing profession's responsibilities in assuring quality of care and

professional accountability via self-regulation (Mullins, Colavecchio, & Tescher, 1979; ANA, 1983; Davis, 1987; ANA, 1988; Whittaker & McCanless, 1988).

Research Questions

1. How do professional and organizational accountability relating to professional nurse reporting differ prior to as compared to after the enactment of 1987 Texas SB 1160?
2. What are the differences in the use of peer review before as compared to after the enactment of 1987 Texas SB 1160?

Definition of Terms

For the purposes of this study, the following terms are defined.

Professional Accountability

As specified in SB 1160, Section 2 (1987) is:

> Each registered nurse having reasonable cause to suspect that a registered nurse has exposed or is likely to expose a patient or other person unnecessarily to a risk of harm because of unprofessional conduct, failure to care adequately for a patient, failure to conform to the minimum standards of acceptable professioal nursing practice, or impaired status shall report in a signed, written report to the board the name of the nurse committing the violation or suspected violation and any other pertinent information within the nurse's knowledge as the board may require. (p. 2266)

Operationalized by Suchman's categories of evaluation as listed in Appendix C under Section 2, Article 4525a, professional nurse reporting.

Organizational Accountability

As specified in SB 1160, Section 2 (1987) is:

> Each hospital, health science center, nursing home, home health agency, other health-care facility, state agency, political subdivision, school of professional nursing, temporary nursing service, or person that employs, hires, or contracts for the services of registered nurses that terminates, suspends, or takes other substantive disciplinary action as defined by the board against a registered nurse because a patient or other person was exposed or is likely to be exposed unnecessarily to a risk of harm because of unprofessional conduct, failure to care adequately for a patient, failure to conform to the minimum standards of acceptable professional nursing practice, or impaired status shall report in writing to the board the name of the nurse and such other pertinent information within the knowledge of the facility, agency, school, or person (p. 2266) and; each hospital, nursing home, health science center, home health agency, other health-care facility, state agency, political subdivision, school of professional nursing, temporary nursing service, or person that regularly employs, hires, or otherwise contracts for the services of 10 or more registered nurses shall develop a written plan for identifying and reporting registered nurses in its service who expose or are likely to expose patients or other persons unnecessarily to a risk of harm because of unprofessional conduct, failure to care adequately for a patient, failure to conform to the minimum standards of acceptable professional nursing practice or impaired status. (p. 2266)

Operationalized by Suchman's categories of evaluation as listed in Appendix C under Section 2, Article 4525a, professional nurse reporting.

Peer Review

Peer review is defined in SB 1160, Section 2 (1987) as:

> Peer review means the evaluation of professional nursing services, the qualifications of professional nurses, the quality of patient care rendered by professional nurses, the merits of complaints concerning professional nurses and professional nursing care, and determinations or recommendations regarding complaints, including: the accuracy of nursing assessments and observations; and the appropriateness and quality of the care rendered by a professional nurse. (p. 2270)

Operationalized by Suchman's categories of evaluation as listed in Appendix C under Section 3, Article 4525b, peer review.

Senate Bill 1160

Senate Bill 1160 is an act "relating to the regulation of professional nursing, the establishment of professional nursing peer review, and certain professional nursing reporting procedures; providing a penalty" (1987, p. 2263) as passed by the Regular Session of the Seventieth Legislature of the State of Texas during 1987. Before enactment of SB 1160 refers to the time period of January 1, 1987 to December 31, 1987. After enactment refers to January 1, 1988 to December 31, 1989.

Limitations of the Study

Selection bias may be a threat to external validity, in that the samples include only registered nurses within Texas. However, this legislation is unique, existing only in Texas. External validity declines as conclusions are extended to more and more strata not considered in the study (Nutt, 1981). Therefore, generalization of this study will be limited to the geographic location of Texas.

Threats to internal validity could be due to maturation of the sample over time. Systematic changes which occur with the passage of time cannot be controlled in non-experimental research.

Summary

In summary, Suchman's conceptual framework for the evaluation process provided the primary structure for this research. In addition, a conceptual framework for accountability was presented to assist in understanding the primary objectives of Senate Bill 1160.

Two research questions were presented. These questions are concerned with SB 1160 mandates (peer review and mandatory reporting) and how they have affected professional nurse accountability in the State of Texas.

CHAPTER 2

REVIEW OF THE LITERATURE

The purpose of this study is to evaluate the effectiveness of SB 1160 in promoting accountability for professional nursing practice within the state of Texas. The primary mechanisms of action established by SB 1160 in promoting accountability were peer review and mandatory reporting. In this chapter, the social evolution of each is discussed particularly in relation to professional, private and public mandates. The majority of the literature on peer review and mandatory reporting deals with the theoretical aspect, therefore, definitions, purposes and benefits are presented. Models of peer review are presented which represent implementation techniques, evaluation criteria and instrument development. Evaluations of peer review programs and legal implications for peer review and mandatory reporting are discussed. Literature dealing specifically with the evolution and implementation of SB 1160 are included.

Social Evolution

Peer review and mandatory reporting have evolved as components of quality assurance and assessment. Quality assurance in nursing implies that a level of quality can

be defined and measured and that the public is assured of that level of care (Lang & Clinton, 1983). Donabedian (1980, 1982) described quality assurance as encompassing a management or clincial process to assure that patients or groups of patients recieve an agreed upon level of care. Quality assessment includes the research and evaluation methodology associated with efforts to measure the quality of care (Lang & Clinton, 1983). Professional accountability has evolved as a social mandate to assure the delivery of quality health care.

The relationship between health care professionals and society grew from the realization that the professions belong to and are the property of the society that grants them rights, responsibilities, and privileges to practice (Steel, 1985). Throughout history, society has granted professions considerable autonomy in the practice of their professions (Hawthorne, Roe & Woods, 1989). In return, the professions have been expected to practice self-regulation to assure quality in performance. One of the first historical indicators that the public demanded accountability in health care is the "Code of Hammurabi," circa 1690 BC. The code regulated the practice of medicine and described penalties for malpractice (Ertel & Aldridge, 1977). Concern about the quality of nursing care has been documented at least since the days of Florence Nightingale (Ott, 1987).

Nightingale implemented the concept that nursing care being rendered must be evaluated in order to assure the delivery of quality care (Smeltzer, 1988).

Peer Review

The impetus for a formal peer review process arose in 1918 (AMA, 1988). The American College of Surgeons wanted to establish a requirement that fellow physicians submit completed records of patients upon whom they had performed major surgery. The records were to be the basis of peer review, however, hospitals kept such poor records that the process could not be implemented. Subsequently, the Program of Hospital Standardization developed minimal standards necessary for the maintenance of an acceptable quality of care for surgical patients, which included peer review. This program led to the formation in 1952 of the Joint Commission on Accreditation of Hospitals, now the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) (AMA, 1988).

In the 1960's, the federal government became involved in the issue of quality assurance through the Department of Health, Education, and Welfare. The Professional Standards Review Organization (PSRO) was funded in 1972 by the federal government to review care of patients in institutions receiving money from the Medicare/Medicaid and Maternal and Child Health Programs.

This PSRO law (Public Law 92-603, Section 249F) created an unprecedented role for peer review as the mechanism for institutional and professional accountability in health care delivery. The law specifically singled out care and services provided in hospitals by physicians to be reviewed for the purpose of determining whether the services were medically necessary and if the quality of care met professional standards (Ertel, 1977).

According to Ertel & Aldridge (1977), the accountability function is the most important variable in the PSRO law. They described three evolutionary developments which led to the passage of the PSRO law: (1) care technology had evolved to the point at which the capability existed to effectively influence the health outcome of significant numbers of clients; (2) society had escalated its demands that health care be uniformly of the highest quality, available, affordable, and that health care providers be held publicly accountable; and (3) evaluation technology had evolved to the point at which it was technically feasible to carry out the mandate of public accountability.

Although the PSRO law was strongly physician-oriented; other health care providers were not excluded. The federal government indicated a level of concern for nurse providers when it awarded the ANA a contract to develop a model set of screening criteria to measure the

quality and effectiveness of nursing care, and to formulate guidelines for the involvement of nurses in review processes and PSROs (Jelinek, R., Haussmann, R., Hegyvary, S. & Newman, J. 1974; Mowry & Korpman, 1986).

The federal government reconfirmed its committment to peer review as a method of encouraging quality health care at a resonable cost by passing the Peer Review Improvement Act of 1982 (Hudson & Ravreby, 1989). The Peer Review Organization (PRO) program was instituted as part of this act, which replaced the PSRO program. This legislation mandated that all hospitals participating in the new prospective payment system must have agreements with PROs to perform medical peer review (Willian, 1984; Staver, 1986). The government contracts with 54 local PROs to monitor the hospital care of Medicare beneficiaries. Texas Medical Foundation (TMF) contracts for PRO review within the state of Texas. The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 gave Medicare PROs the power to deny payment to providers whom the PROs determined rendered substandard care (American Hospital Association, 1987).

In 1987, the Health Care Financing Administration (HCFA) established a set of requirements for PROs in health maintenance organizations (HMOs) and other competitive medical plans (CMPs) (Micheletti, Shlala, & Freedman, 1988). These PRO reviews focused on appropriate utilization management in both inpatient and

outpatient settings. Previously they had focused primarily on inpatient settings. The new requirements were established to ensure that physicians and other health professionals review the processes involved in the provision of health care and include a system of collecting data on provider performance and patient outcomes (Public Health Service Act, 1987).

The Omnibus Budget Reconciliation Act of 1989 (Public Law 101-239) contained a provision which relates to PROs. This act required that PROs establish procedures for the involvement of health care practitioners, other than physicians, in the review of services provided by members of their profession (M. Vanderbilt, ANA Senior Staff Specialist, personal communication, January 17, 1990). This provision codifies the existing efforts ongoing in peer review organizations to incorporate non-physicians into the review of their peers.

The effectiveness of PROs was questioned by Mandelbaum (1987), who suggested that PROs are generally physician-dominated and fail to have enforcement power. Since most PROs deal with Medicare and Medicaid review and membership is voluntary, a member can resign at any time, and thereby avoid complying with any sanction or action taken. However, Gross (1984) stated that PROs are the most comprehensive

cooperation between health care professionals and the federal government to attempt to achieve effective peer review and that the system works when properly applied.

The Health Care Quality Improvement Act of 1986 (Title IV, Public Law 99-660) authorized creation of the National Practitioner Data Bank (Windom, 1989). This legislation had two stated purposes: encouraging professional peer review; and restricting the ability of incompetent health care practitioners to move from state to state without discovery of previous sub-standard performance or unprofessional conduct via mandatory reporting. This act also provided immunity from prosecution for those health care providers and organizations who reported incompetent health care practitioners. Subsequently, Public Law 100-93 (1987) expanded the data bank operation to protect beneficiaries of the Medicare and Medicaid program from unfit health care practitioners (Wilson, 1988). The Data Bank and reporting requirements became effective in 1990 (Lockhart, Poe, and Wilcox, 1990).

In 1971, the American Medical Association (AMA) issued a comprehensive, two-volume Peer Review Manual to encourage promotion of the peer review process as an essential mechanism for evaluation and analysis of medical care (Brown & Sale, 1974). Since 1979, JCAHO has given increased emphasis to ongoing review and evaluation of the

quality of care delivered to consumers (Luke, Krueger, & Medrow, 1983). Fifteen years after the nursing profession recommended an active accountability program for the profession, the JCAHO established the requirement of quality assurance for nursing (Smeltzer, 1988).

The American Nurses' Association's commitment to implementing peer review was evident as early as 1973, when guidelines for peer review were prepared under the direction of the Congress for Nursing Practice (ANA, 1973). The document demonstrated an understanding of nursing leaders that peer review was a necessary part of implementing standards of practice. The concepts of peer review were subsequently incorporated into such ANA publications as Guidelines for Review of Nursing Care at the Local Level (1976), Quality Assurance Workbook (1976), and Nursing Quality Assurance Management/Learning System (1982). In addition, ANA published Peer Review in Nursing Practice (1983) and Peer Review Quidelines (1988) to reinforce for nurses, other health professions, and regulatory agencies, the self-regulating nature of the nursing profession. All of these publications were based upon ANA's perceived responsibility to the public and to its members to facilitate the development of a quality assurance system including peer review.

According to the ANA (1983), another significant activity in the evolution of peer review in nursing has

been the delineation of generic and specialty standards of practice. ANA's publication Nursing: A Social Policy Statement (1980), which describes nursing's social responsibility and the nature and scope of practice, completes the professional elements needed as the basis for a public position on peer review in nursing.

Over the past two decades, peer review has gained attention from nursing leaders. Passos (1973) referred to peer review as the hallmark of professionalism and the mechanism by which the nursing profession would be held accountable. Ramphal (1974) described peer review as a method by which nurses could regulate their practice. According to Joel (1984), peer review is an instrument which safeguards the integrity of the profession and honors commitment to the public trust.

The National Commission on Nursing in 1983 created the National Commission on Nursing Implementation Project (NCNIP). NCNIP proposed a model for building nursing care delivery systems of quality and cost-effectiveness. The theme of accountability is woven throughout NCNIP's model and peer review is stressed as a mechanism for accountability (Simpson & Waite, 1989).

Mandatory Reporting

The concept of mandatory reporting is not new. Mandatory reporting of venereal diseases and child abuse has existed for many years (Luckenbill-Brett & Stuhler-

Schlag, 1987). The National Council of Boards of Nursing advocates mandatory reporting and has developed model acts and regulations for boards to use in instituting such policies. Many states have amended their Nurse Practice Act to cover mandatory reporting; currently 18 states have mandatory reporting for nursing (M. Kelly, Director of Public Policy Analysis, National Council of State Boards; personal communication, June 22, 1989).

The National Practitioner Data Bank provided for a national mechanism of mandatory reporting. The data bank will collect and supply information on misdiagnosis and malpractice, misconduct, revocation and limitation of privileges, judments and settlements, and all disciplinary measures taken by hospitals, courts, licensing boards, professional associations, insurers and peer review committees. Agencies will have to report such actions to the National Practitioner Data Bank or face fines of $10,000. for each failure to report (Wilson, 1988; American Journal of Nursing, 1989).

The Data Bank will supply information to licensing boards and health care facilities that are investigating applicants. The law requires hospitals to contact the bank before granting staff privileges. The bank will not store such personal information as arrests and drug and alcohol abuse unless they are pertinent to job performance. Health care practitioners will be allowed

to review their own records, however, the public will not have access to the data. Although the program will initially focus on physicians, it will eventually include other health care providers such as nurses (C. Taplin, Administrative Assistant, U.S. Department of Health & Human Services, National Practitioner Data Bank; personal communication, June 27, 1989).

The Texas Medical Practice Act was amended in 1987 to take advantage of the immunities provided in the Health Care Quality Improvement Act (HCQIA) of 1986, which provided immunity from liability for certain professional review actions (Wilcox, 1987). The immunity protections became available in Texas on September 1, 1987, when the state opted into the HCQIA. By amending the Medical Practice Act, Texas law imposed an additional requirement not required by the HCQIA: the act requires medical peer review committees, licensed physicians, and medical students to report to the Texas State Board of Medical Examiners any physician who is believed to pose a continuing threat to the public welfare through the practice of medicine (Lockhart, Poe, & Wilcox, 1990). There is no similar requirement in the federal law. This amendement to the Texas Medical Practice Act was legislated by House Bill 2560 which is very similar to SB 1160.

Definitions, Purposes and Benefits

Definitions

According to the ANA (1988), the generally accepted definition of peer review is an organized effort whereby practicing professionals review the quality and appropriateness of services ordered or performed by their professional peers. Peer review in nursing is "the process by which registered nurses, actively engaged in the practice of nursing, appraise the quality of nursing care in a given situation in accordance with established standards of practice (ANA, 1973, p.1)." In 1975, the ANA defined peer review as "the process by which practicing nurses systematically assess, monitor, and make judgments about the quality of nursing care provided by peers as measured against professional standards of practice (ANA, 1975)." This last definition is the one most recently published in the ANA 1988 Peer Review Guidelines.

Ramphal (1974) defined peer review as the evaluation by practicing nurses of the quality of care provided by other nurses in accordance with the stated norms of the profession. Zimmer (1974) suggested that peer review and accountability are often used as synonyms for quality assurance. Zimmer defined peer review as "a formal, concurrent or retrospective, critical examination with a view toward future improvement of the activities and

outcomes of care for a very specific patient population" (p.93). Vengroski & Saarmann (1978) defined peer review as "the examination and evaluation of an individual's clinical nursing practice by associates" (p. 2095). They correlated peer review and audit as opposite sides of a coin, representing quality assurance. Mullins, Colavecchio, & Tescher (1979) described peer review as a model for professional accountability which involves the examination of an individual nurse's practice through critical self-appraisal and validation by colleagues according to an externally defined standard.

In 1983, Steel described peer review as "a process used systematically by the professional nurse to assess, monitor, and make judgments about the quality of care provided by other nurses in similar positions, and is consistent with the profession's responsibility to the public for standard setting" (p.5). Peer review is defined by O'Loughlin & Kaulbach (1981) as "a process by which practitioners of the same rank, profession, or setting, critically appraise each other's work performance against established standards" (p. 22). Anderson & Davis (1987) stated that peer review is the process by which professional staff nurses critically appraise the nursing process, as measured against established standards, and these nurses provide direct feedback to their peers for corrective action to be taken.

Peer review is the ability to critically analyze peers against predefined behaviors (Davis, 1987). Beckman (1987) described peer review as "an organized system by which professionals evaluate the performance of their peers in achieving standards" (p. 77). Peer review is the evaluation of the clinical component of practice; it includes the objective assessment of the nurse's comprehensive collection and interpretations of data, subsequent conclusions, and nursing plans (Woolard & Peterson, 1989). A recent definition by Christensen (1990) described peer review as the examination and evaluation according to written standards by associates of a nurse's clinical practice.

Definitions of peer review by the medical profession are very similar to those of nursing. In 1973, Decker & Bonner defined peer review in relation to PROs as a means to apply collective professional judgment to individual or group medical performance. Ertel & Aldridge (1977) defined peer review as:

> the investigational, managerial, and educational process for systematically monitoring medical and health care in which the judgments regarding provider performance and recommendations regarding corrective actions are based on a review of appropriate case data and are made by qualified professional peers who practice in the same community and who communicate the results of their efforts to the public. (p. xii)

The AMA (1988) defined peer review as the evaluation by practicing physicians of the quality and efficiency of

medical care services ordered or performed by other practicing physicians; it is the basis of any program to assess the quality of medical care.

Definitions of mandatory reporting are limited in the literature. Cloutier (1981) defined reporting as an act based on the judgment that a professional's actions violated the practice act and that withholding the information in order to avoid personal or professional difficulties would be equally inappropriate. Mandatory reporting is reporting of incompetence or violations of the professional practice act as mandated by regulatory or legislative entities (Green, 1989). While Cloutier's definition of reporting implies an ethical obligation, mandatory reporting involves both legal and ethical dimensions.

Purposes

The primary purpose of peer review is to establish profession accountability for the delivery of quality nursing care; most stated purposes focus on accountability and quality assurance (ANA, 1973; Zimmer, 1974; Steel, 1985; ANA, 1988). Peer review fulfills one dimension of professional accountability (Zimmer, 1974) and its purposeis to assure the public that nursing is monitoring the work of the nurse (Steel, 1985). A primary goal of quality assurance is accountability for quality of care. Peer review is a mechanism to

operationalize accountability among the nursing profession's practitioners (Beckman, 1987).

The ANA's (1973) original statement regarding the purposes of peer review included: to evaluate the quality and quantity of nursing care; to identify the extent of consistency to established standards; identify strengths and weaknesses of nursing care; to provide evidence to improve nursing care; and to identify areas of practice where more knowledge is needed. Those same statements are identified in ANA's 1988 publication Peer Review Guidelines.

The purposes of peer review when identified within specific institutions tend to focus on the individual nurse. These purposes include providing an evaluation mechanism on a peer level; identifing areas of growth and development; increasing job recognition by peers; enhancing professional growth; and identifying behaviors not in compliance with standards and correcting those deficiencies (Mullins et al., 1979; O'Loughlin & Kaulbach, 1981; Anderson & Davis, 1987; Davis, 1987; Woolard & Peterson, 1989).

Benefits

Individuals, institutions, and the nursing profession all derive benefits from an effective peer review program (ANA, 1988). Peer review stimulates professional growth and clinical knowledge for those

involved. Institutional benefits include identification of educational and administrative patterns which need to be changed to ensure quality; areas for research are also identified. Numerous benefits to the profession and consumer are identified by ANA (1988) including: assures the consumer of the nurse's continued competence; provides an avenue of aribitration of consumer complaints; provides legal protection for unjust professional misconduct charges; rewards competent nursing practice; increases self-regulation of the profession; increases control over nursing practice; improves documentation, communication and productivity; and enhances quality assurance.

For nursing as a whole, peer review is an avenue for identifying levels of competence, assisting the profession to clearly define practice by setting criteria and standards and evaluating practitioners against these standards (Vengroski & Saarmann, 1978). Moreover, a peer review system should lead to improved payment patterns that include specific reimbursement for nursing diagnosis and treatment (Steel, 1985).

The benefits of mandatory reporting are primarily related to safeguarding the public and the nursing profession (Greenlaw, 1980; Moyer, 1987). Most mandatory reporting laws are designed to protect the public, but at the same time also protect the reporting professional

from defamation liability. Many states have reported an increase in the filing of complaints following enactment of mandatory reporting (Luckenbill-Britt & Stuhler-Schlag, 1987). This can probably be related to the fact that mandatory reporting laws clarify who is responsible for reporting; this places the reporting professional at risk of unprofessional conduct for failing to report.

Mandatory reporting is controversial for many professionals; reporting activities may be judged legal but perceived as unethical by the professional. Numerous authors refer to "whistleblowing" in reference to reporting of incompetent practitioners (Cloutier, 1981; Kleinfield, 1986; Kiely & Kiely, 1987).

Perhaps the most vital and far reaching benefit of peer review (Vengroski & Saarmann, 1978) and mandatory reporting is for ethical practice. The ANA Code for Nurses (1976) clearly requires each nurse to maintain competence and to report the incompetence of others. It maintains that a nurse must be willing to take the appropriate measures necessary when aware of incompetent, unethical, or illegal behavior by other members of the health care team. Peer review and mandatory reporting provide mechanisms to enforce the Code.

Peer Review Models

The nursing literature provides evidence that nursing peer review has been implemented in a variety of

health care settings. This literature indicates that peer review must be operationalized somewhat differently in different settings. Numerous authors have provided descriptions of peer review models, evaluation criteria and instrument development. Although the settings described below are all different, the principles of peer review remain the same.

In 1972 a contract was awarded by the Division of Nursing, Bureau of Health Resources Development to Rush-Presbyterian-St. Luke's Medical Center and the Medicus Systems Corporation to develop and test an instrument for monitoring the quality of nursing care (Hegyvary & Haussmann, 1975). Phase III of this research was aimed at adapting this instrument for concurrent review of nursing care in a manner consistent with approaches taken for physician review under the PSRO law (Hegyvary & Haussmann, 1976). The Rush-Medicus quality monitoring instrument developed in previous phases of this project provided a detailed profile of nursing performance. The instrument relied extensively on both record review and patient interview; it reviews the nursing process taking place for a given group of patients over a defined period of time from a random sample of the group. The instrument was reported to be reliable and valid. Phase III of this project attempted to develop a system for nursing professional review which provided for:

screening of selected patient outcomes to identify both poor and excellent consequences of nursing care; systematic monitoring of nursing practice focused on nursing interventions expected to affect key patient outcomes; and evaluation studies to analyze the relationship of nursing practice and patient outcomes.

In 1975, nurses in a county health department reported implementing a peer review system which involved the use of a rating scale of ten facets of interpersonal communication (Johnson & Zimmerman). No reliability or validity for the scale was reported. Vengroski & Saarmann (1978) described the implementation of peer review on an intermediate care unit practicing primary nursing. ANA standards were used as the basis for peer review. Mullins et al. (1979) described implementation of a peer review process for the classification, promotion, and ongoing evaluation of professional nurses in a large university hospital. This process involved a peer review committee consisting of nurses and consumers; no criteria for review were discussed.

O'Loughlin & Kaulbach (1981) described a peer review appraisal process developed for evaluating a professional staff of primary nurses on a neurosurgical unit. This system provided for periodic reviews of individual staff members by a few of their peers. ANA standards for neurological and neurosurgical nursing practice were

incorporated with Orem's framework for nursing practice to develop the "Professional Skills Appraisal Tool". The tool assisted peers in evaluating how standards were met and the rationale for the nursing decisions made. Profiles included are technical competence, communication skills, organizational skills, originality, judgment, assertiveness, achievement, and human relationship skills. No reliability or validity for this instrument was reported. Interviews with patients who were cared for by the nurses and chart audits comprised part of the evaluation process. The authors stated that this system was perceived as threatening, not only by the nurse being reviewed, but also by peers performing the review. The authors stressed the need for nurses to come to accept peer review as a valid form of professional evaluation, despite the difficulties encountered in this pilot program. No formal evaluation of effectiveness was reported.

A group of clinical nurse specialists described a peer review system using three tools: job descriptions, a clinical evaluation tool based on the ability to integrate knowledge about the nursing process, and a communication tool (Blanton et al., 1985). A model for peer review was integrated with a clinical ladder at a pediatric tertiary level hospital (Davis, 1987). Eight categories of behavioral criteria including assessment,

planning, implementation, evaluation, leadership, teaching, ethics and professionalism were used. Participation in the process was entirely voluntary and required application to a selection committee. Peer review was considered a critical facet of the program and the most difficult.

At a large southwestern hospital, a group of certified nurse-midwives reported participation in peer review of both group and individual practice (Martinez & Mariella, 1986). The process was viewed more as an evaluation of health care provided rather than a personal criticism of individual providers. Topics were selected by the peer review committee and objective criteria for evaluation of management are used. Peer review was performed with the entire group once a month. This system combined chart reviews, case presentations and inservice education. The benefits derived from this program were reported as: providing a forum for evaluation of accepted standards of practice; presentation of new or alternative concepts of management of care; appropriate updating of institutional policies; and evaluation of adherence to policies and procedures and completeness of documentation.

One of the most unique reports is Hickey's (1986) description of incorporating peer review into a cardiovascular clinical nurse specialist curriculum. A

peer review experience was incorporated into a 15-week clinical course in which students were responsible for managing a caseload of patients. This included an orientation to peer review followed by each student presenting a case for peer review. Peer review was defined as the evaluation of practice by peers according to the ANA's standards for cardiovascular nursing. Two basic purposes for incorporating peer review into a curriculum for graduate students were described by the authors. First, students needed exposure to peer review to socialize them to an evaluation process performed by colleagues and peers; secondly, it provided students with an opportunity to validate their practice through nursing care standards and measurable outcome criteria. Although no long term evaluation was performed, the author reported a favorable outcome for this innovative program.

In 1986, a group of nurses reported implementation of a peer review system within a staff development department of a large medical teaching center (Fierman et al.). A peer review task force was formed which developed two objective instruments and a system for use of the instruments. Both instruments incorporated a behavioral scale; no reliability or validity was reported. Gaustad (1986) reported implementation of a peer review system involving evaluation of three major areas: the decision making process; therapeutic

interventions; and the rationale and sequence of steps in patient care that help the patient reach goals.

Group peer review focusing on the process aspect of nursing practice was implemented at a large midwestern medical center (Anderson & Davis, 1987). An instrument, entitled "Process Review of Nursing Care," was developed to evaluate the process of nursing care delivery. The conceptual framework for this instrument was Maslow's hierarchy. No reliability or validity was reported for the instrument. A random review of individual patient care was performed each month by members of a peer review committee. The authors reported that the use of this process enhanced professional accountability and assisted nurses in setting their own professional standards and goals.

Hawthorne et al. (1989) described a peer review system in a large university hospital based on two-components: chart audit; and audit of nurse behaviors based on observation of nursing care, interpersonal skills, and communication skills. Two instruments were developed to evaluate each component. This peer review system consisted of both group (unit) and individual reviews. An evaluation of the program was completed after one year. The results were utilized to detect deficiencies in the system and to suggest needed adaptations.

Woolard and Peterson (1989) described the development of a peer review system in a nurse-directed college health service. Bushy and Tyler (1989) described the implementation of an interdepartmental quality assurance program in a small rural hospital. Interestingly, a medical peer review system was developed, but there was no mention of nursing peer review, even though both authors were nurses. A concurrent peer review system was developed by a group of flight nurses (Eastes, 1989) in which review of appropriateness of care by specific diagnosis was utilized.

Bedell and Gebhart (1989) reported the use of a group process format for peer review by the perioperative nursing staff of a military medical center. This peer review process allowed nurses to evaluate the degree to which standards were met, identifing strengths and weaknesses of individual nurses performance, and promoting group cohesiveness. Perioperative nursing standards were used as objective criteria for evaluation of case presentations of care delivered. The authors reported benefits of the program as increased awareness of nursing care and outcome standards, and enhanced nursing competency.

Peer Review Program Evaluation

A major purpose of evaluation and evaluation research is to provide useful information for judging

decision alternatives in program planning (Lang & Werley, 1980). There is a limited amount of information in the literature regarding evaluation of the effectiveness of peer review programs. Two evaluations of nursing peer review were found, one focusing on effects upon staff nurses, the other upon patient care outcomes. Three medical evaluation studies were found, two examining methods of peer review, the other evaluates patient care outcomes following implementation of peer review.

A 1985 study examined the effects of peer review upon staff of two intensive care units in a large university hospital (Mio, Speros & Mayfield). Three variables were measured in an attempt to determine the effects of peer review: the nurses' opinions of the process; the Tennessee Self-Concept Scale's Social Self dimension; and a memory for positive events task. Twenty critical care nurses participated in the study; ten in the experimental group participated in peer review and ten in a control group were evaluated by supervisors. A one-way analysis of variance performed on the opinion data yielded a highly reliable difference between groups ($F=10.781$, $p<.001$). The group experiencing peer review had a more favorable opinion of the evaluation process than the control group. A t-test performed on the Social Self Scale and the memory for positives task indicated no significant differences between the groups. The authors

suggested the results indicate that peer review of critical care nurses is superior to traditional supervisory evaluation. Reliability and validity of the instruments were not reported.

Whittaker & McCanless (1988) described a 12-month evaluation study conducted to determine the impact of a nursing peer review program at a large university hospital. Twelve categories of variations in patient outcomes were identified as substandard. As a result of this evaluation, actions were taken to correct these deficiences; these actions included policy and procedure review, inservice programs, counseling/disciplinary action, and communication with staff.

Brock (1973) described a medical study which examined variation in the assessment of quality of care as a function of the peer review method by which it is measured. Five peer review methods were selected for study: the adequacy of the medical care process was judged after reading a detailed case abstract; patient outcome was judged as improvable or unimprovable after reading a medical abstract containing data concerning both the medical care process and four outcome parameters measured during a follow-up interview; the acceptability of quality of care was judged by combining the assessments made in method 1 and 2; the adequacy of the medical care process was measured against a list of

process criteria; and evaluation of quality of care was determined from estimations of various group outcome parameters. Two hundred ninety-six patients with either a urinary tract infection, hypertension, or a peptic ulcer were included in the study. Medical charts were reviewed and each patient was interviewed five months following their initial visit. Two groups of physicians were randomly selected to participate, generalist and specialists. The results indicated that different peer review methods will produce substantially different results when measuring quality of care. It was suggested that the most valid approach to assessing quality of care is individual case analysis of both medical care process and patient outcome.

McAuley & Henderson (1984) described the experience of the College of Physicians and Surgeons of Ontario in developing and conducting a peer review program of physicians' office practices. Two pilot projects were used to identify an acceptable approach and to access the need for a peer review program. The first pilot developed a model for peer review and the second pilot tested this model. A group of physicians reviewed the care provided by 391 physicians participating in the second pilot. A review of standardized records by the reviewers revealed an inter-rater reliability of 90% and high level of face and construct validity. Of the 391

physicians reviewed, it was found that 83% had satisfactory records and levels of care, 8.5% had deficient records but satisfactory levels of care, and 8.5% had deficient records or unsatisfactory levels of care or both. A plan was developed with the individual physician to correct the deficiencies. Upon followup 60% of the physicians had corrected the identified deficiencies. The program was deemed beneficial and was subsequently implemented for all of Ontario.

In 1987, the Texas Medical Association conducted a study of peer review in Texas in preparation for the 1987 legislative session (Ross, 1987). This study surveyed two groups of physicians: medical staff involved in the peer review process and practicing physicians. The sample for the first group is stated as small but representative of a substantial portion of physicians involved in peer review in Texas. The second group was described as larger and statistically valid. The two groups were reported to have identical responses on key questions, indicating a close correlation between the sampling of medical staff participants and the practicing physician population. No correlational statistics were provided.

Descriptive statistics were provided in several categories. Respondents were asked to rate the effectiveness of peer review. Twenty-one percent of all

respondents rated themselves as having excellent effectiveness with peer review. Fifty-one percent felt they were doing a good job, seventeen percent felt their efforts were only fair and seven percent rated themselves as having poor effectiveness. The most effective mechanism of peer review utilized was hospital staff review; county medical society review and Medicare/PRO were rated as the least effective.

The primary factor thwarting the effectiveness of peer review was the threat of a lawsuit. Sixteen of the responding physicians said that the threat of a lawsuit made them very reluctant to participate in peer review and fifty-one percent were somewhat reluctant. The results of this study were used for its public policy implications during the 1987 Texas Legislative session in drafting of House Bill 2560, which mandated peer review for physicians and provided immunity from prosecution (Ross, 1987).

Legal Implications

Peer review and mandatory reporting have numerous legal implications for health care professionals. Today, regulatory agencies of both federal and state government, legislation and case law provide the foundation for determining the health care providers concomitant responsibility toward patients. Concern has been expressed by both nurses and physicians regarding the

legal implications of peer review and mandatory reporting.

Bennett (1985) cited the case of Darling v Charleston Memorial Hospital, 1965, in which the court addressed for the first time the hospital's duty to review the credentials of physicians seeking staff privileges and to monitor their conduct after admission to the medical staff. Subsequently, hospitals developed elaborate peer review structures for physicians, but have failed to do so for nurses (Bennett, 1985). It is suggested that nurses who find themselves in positions where liability may exist for failing to credential or peer review employees should insist immediately upon the implementation of an effective peer review mechanism.

The relationship between defamation, specifically libel and slander, and peer review were explained by Klein (1986). Peer review committee participants generally have immunity from libel and slander because of the need for candid commentary. However, it is stressed that participation in peer review does not give one license to defame another. Testimony should be in good faith and given with reasonable belief that the statements made are true. Individuals against whom testimony has been given should have the opportunity for self-defense. Peer review committees should have policies addressing the collection and dissemination of information and consequent action. Klein (1986)

suggested several steps for reducing the risk of a slander suit in a peer review situation. Committee membership should be monitored to protect against a conspiracy targeted at another; malice should be avoided by having evidence that supports the decisions made; and written and verbal communication regarding the committee affairs should be guarded.

According to Ross (1987), legislation dealing with the peer review process should encompass the following legal elements: confidentiality; civil immunity; bad faith counterclaims; due process; and reporting of final actions. Confidentiality should be an essential component of the peer review process, including being non-breachable through a subpoena or court order. Civil immunity should be provided for "good faith" peer review activities. In the event of a retaliatory suit against a peer review committee, all costs attributable to such a suit should be recoverable by the defendant if the peer review committee's efforts are found to have been conducted in good faith and without malice. The professional undergoing peer review should be given due process, including proper notice, reasons for the action, right to a hearing, reasonable time limits within which to request a hearing, and the ability to review the basis for the proposed sanctions. Any final, substantive, and adverse disciplinary action that the peer review

committee takes should be reported to the appropriate regulatory agency.

The recent Supreme Court opinion in Patrick v Burget has caused concern about the legal liabilities associated with participation in medical peer review (Veer, 1985; AMA, 1988; Rifkin, Evans & Hall, 1990). Patrick affirmed a $2.2 million antitrust verdict against physicians who allegedly misused the peer review process to eliminate a competitor. The AMA Committee on Medical-Legal Problems issued a report on this issue and suggested how to conduct safe peer review (AMA, 1988). Physicians were also encouraged to support legislation that would reduce the risk of antitrust lawsuits. Rifkin, Evans, & Hall (1990) suggested that the Health Care Quality Improvement Act of 1986 was passed primarily as a result of the Patrick case. Physicians conducting peer review activities felt they might be exposed to damage suits by physicians who, after losing their hospital privileges, would contend that the peer review action was performed under the guise of violating the physician's legal rights.

It was hoped that the Health Care Quality Improvement Act would alleviate those concerns, thus promoting a more effective peer review system. Hudson & Ravreby (1989) suggested that often peer review legislation imposes undue regulations, resulting in

numerous legal problems for the practitioner. Beaird (1987) and Perry (1990) defended peer review regulations, advising physicians how to "win" or "deal" with the process. Articles instructing physicians how to cope with or respond to a peer review inquiry stressed the legal implications involved (AMA, 1989; Hornbake, 1990).

Literature Specific to SB 1160

Brooks (1987), a sponsor of the bill, analyzed the background and purposes of SB 1160. A major factor contributing to this legislation was the limited number of practice related complaints received by the Board of Nurse Examiners. In fiscal year 1986, approximately 109,000 professional nurses were registered with the board. During the same time period, the board received 400 complaints, only 15% of which were related to patient care. The BNE and the Texas Nurses Association indicated the number of complaints probably did not accurately reflect the number of violations related to patient care due to a lack of mandatory reporting requirements for health care providers (Texas House Public Health Committee, 1987). Brooks (1987) also noted that health care providers were reluctant to report allegations to the BNE due to fear of legal action against the reporting party.

Willmann & Jordan (1987) provided a clearer background of the evolution of SB 1160. In addition to

the factors identified above by Brooks, they identified additional factors which led to the drafting of SB 1160. Consumer demand for higher quality health care resulted in a national trend toward malpractice suits, which resulted in higher malpractice rates for health care providers. Legislative responses to these trends resulted in: tort reform to make suing less attractive; insurance reform to make the insurance industry more accountable and competitive; and stricter regulation of health care professionals in response to consumer demands.

In addition, pressure was asserted on both the medical and nursing professions by negative press coverage of incompetent practitioners (Willmann & Jordan, 1987). The medical profession began drafting HB 2560 in response to these pressures and to obtain legal protection via "opting" in on the federal Health Care Quality Improvement Act. Nursing legislation was drafted as a logical extension to these factors.

Brooks (1987) described the purposes of SB 1160 as: to improve the enforcement of the Nurse Practice Act; provide protection for persons reporting incompetent practitioners; and to establish professional peer review for registered nurses. Jacobs (1987) described the merits of the bill in the Texas Senate Health & Human Services Committee hearing as strengthening and expanding the mandatory reporting of violations of the nurse

practice act and providing quality assurance to the public by the use of peer review focusing on practice issues. The previous nurse practice act did not specifically require mandatory reporting or professional peer review. The bill also provided immunity for those reporting in "good faith".

The Texas Nurses Association published Implementing the Nursing Quality Assurance Act in the Workplace to provide general information about SB 1160 and how to implement the peer review and mandatory reporting components of the bill (Willmann & Jordan, 1987). In the overview of SB 1160, numerous components of the bill are outlined as significant. The bill established new practice-related disciplinary grounds based on the failure to adequately care for patients or to conform to minimum standards of acceptable professional nursing practice, that in the opinion of the BNE, exposes a patient unnecessarily to risk of harm. The bill established three categories of reporting requirements: mandatory reporting of unsafe care to the BNE by individual RNs, hospitals and health care agencies, professional associations and certification bodies, insurance companies, and the judicial system; permissive reporting of health care facilities and other health care providers; and optional reporting to the peer assistance program.

Other components of the bill identified by Willmann & Jordan (1987) included the encouraging of reporting by provisions of protection for the reporting party and sanctions for failure to report. The bill also protects the nurse being reviewed by establishing the right to notification, review of the committees' report, and the right to make a rebuttal statement. Nondisclosure of findings is not permitted until the BNE has completed it's investigation, except to prospective employers. Confidentiality is supported with minimal disclosure allowed in very specific circumstances. The BNE was also granted increased subpoena power to investigate reports. Based on the demand for public accountability, the BNE is required by the bill to publicize disciplinary actions taken.

The BNE published it's own guidelines for implementing the peer review process (BNE, 1989). These guidelines indicated that SB 1160 mandated a peer review committee to investigate all reportable incidents (as identified in Article 4545a, Section 2b), which supports a reactive utilization of the peer review process. The guidelines suggested that an optional purpose of peer review may be to promote and improve nursing care and/or to modify conditions that impede the performance of nursing care. This option is described as proactive utilization of the peer review process (BNE, 1989).

The BNE was responsible for the implementation of mandatory reporting and peer review; this responsibility arose from it's power to enforce the Nurse Practice Act. Mandatory reporting became effective on September 1, 1987 and the provisions for a written plan for peer review became effective on January 1, 1988. Both the BNE and the Texas Nurses Association provided workshops and written information to assist in the implementation of peer review and mandatory reporting through out the state of Texas.

According to Waddill (1988), the Executive Secretary for the BNE, following the passage of SB 1160 there was a dramatic increase in the number of practice-related complaints reported to the BNE. Waddill (1988) also indicated that some confusion existed concerning the implementation of peer review, reporting to TPAPIN, and when to report to the BNE.

In 1988, the BNE undertook an evaluation study to examine the implementation of the quality assurance provisions in SB 1160: mandatory reporting and peer review. This study also examined the rules for the delegation of selected nursing tasks to unlicensed personnel by registered nurses. The purposes of this evaluation study were identified as: to identify problems in the implementation of SB 1160; to provide information that would indicate whether or not the operations of the

BNE served to fulfill its mission of public protection; and to demonstrate the BNE's accountability with regard to enforcement of the Nurse Practice Act (Houfek, Waddill, Crismon, & Francik, 1990).

Data was collected via surveys of nurse administrators, peer review committee chairpersons, registered nurses and nurse surveyors; semi-structured interviews with the Board's investigators; and a review of selected disciplinary records of the BNE (Houfek, et al., 1990). Responding to the survey were 197 nurse administrators, 155 peer review commitee chairpersons, 303 RNs, and 45 nurse surveyors. Data analysis included descriptive and nonparametric procedures. No reliability or validity was reported for the survey instrument.

Aspects of the BNE study closely correlate with this research. When peer review chairpersons were asked to rate the effectiveness of the peer review process, chairpersons took a noncommittal approach: 36% did not respond, 28% stated peer review was moderately effective, and only 8% rated peer review as extremely effective (Houfek, et al., 1990). Chairpersons also identified peer review as a time-consuming and costly process, which often resulted in anxiety for participating nurses. The majority of the RNs surveyed (72%) reported having no experience with the peer review process. RNs were

concerned about the confidentiality of peer review proceedings and did not perceive that they had sufficient input in selecting peer review committee members (Houfek, et al., 1990). In regard to mandatory reporting, 34% of the RNs stated they had not incorporated mandatory reporting requirements into their practice, while only 17% indicated they had.

In monitoring health care facilities' compliance with mandatory reporting and peer review, 44% of the nurse surveyors reported they did not collect information concerning compliance with mandatory reporting during surveys. Thirty-seven percent did not collect information about compliance with peer review (Houfek, et al., 1990). One recommendation of the study was to consider ways to strengthen the enforcement components of mandatory reporting and peer review requirements.

In the BNE's Executive Summary (1990) of the study, overall results were reported as not revealing any major problems with the implementation of the quality assurance provisions of SB 1160: mandatory reporting and peer review. Other recommendations included continued study of the implementation and effects of these quality assurance mechanisms; exploration of ways to keep RNs informed of BNE activities; consider issuing additional guidelines to facilitate uniform compliance with SB 1160; and consider compiling data to monitor compliance with

mandatory reporting and peer review (BNE, 1990).

Summary

Peer review and mandatory reporting have evolved as social mandates for professional accountability and quality health care. Definitions, purposes and benefits described in the literature are basically dervied from a proactive approach to the peer review process. Mandatory reporting is described as a reactionary mechanism for consumer protection and should provide legal immunities for the reporting entities. Both mandatory reporting and peer review appear easier to describe in the theoretical context than they are to operationalize in health care settings.

CHAPTER 3

PROCEDURE FOR COLLECTION AND TREATMENT OF DATA

A nonexperimental, explanatory evaluation research design was used to examine the effects of SB 1160 in promoting nursing accountability in the State of Texas. According to Woods & Catanzaro (1988), the purpose of evaluation research is to determine the ability of an intervention (e.g. SB 1160) to achieve the intended effect (e.g. enhanced quality of nursing practice via increased accountability). Krueger (1980) suggested that evaluation research is undertaken to provide information for decisions to safeguard and improve care.

A summative evaluation approach was utilized to examine the differences in nursing accountability prior to as compared to after the enactment of SB 1160. Weiss (1972) stated that summative evaluation research provides information about the effectiveness of a program or policy and its goals. Therefore, one of the first steps in evaluation research is determining the goals or objectives of a program or policy. The goals of SB 1160 are included in Appendix A.

A non-experimental design using survey techniques which are described as relevant to evaluation research was used to answer the research questions.

Non-experimental designs can provide a preliminary look at the effectiveness of a program or policy (Weiss, 1972; Bellinger, 1980). Non-experimental designs are the least structured, but most frequently used, evaluation research designs (Poister, 1978).

Using Suchman's (1967) categories of evaluation, each research question was related to five areas: effort, performance, adequacy of performance, efficiency, and process. Quantitative and qualitative methods were used to analyze the survey data generated from these categories of evaluation (Appendix C).

Research Question One

Professional and organizational accountability related to professional nurse reporting were categorized and measured according to:

1. Effort - pertaining to BNE staff hours in handling professional nurse reporting prior to as compared to after enactment of SB 1160. Data were collected by abstract of BNE records and semi-structured interviews of BNE staff.
2. Performance - relating to yield of suspected cases of nurses practicing below the current standards of practice prior to as compared to after enactment of SB 1160, as reported by: registered nurses; organizations; professional associations; state agencies that survey health care facilities; insurers

of professional liability insurance; and attorneys representing the state. Data were collected by abstract of BNE complaint log of suspected incompetent practitioners.

3. Adequacy of performance - relating to yield of formal charges filed by the BNE or final disciplinary action taken by the BNE prior to as compared to after enactment of SB 1160, as related to professional nurse reporting by: registered nurses; organizations; professional associations; state agencies that survey health care facilities; providers of professional liability insurance; and attorneys representing the state. Data were collected via abstract of BNE records.
4. Efficiency - estimates of costs expended by the BNE in relation to adequacy of performance of professional nurse reporting prior to as compared to after enactment of SB 1160. Data were collected by abstract of BNE performance and funds management reports.
5. Process - was examined according to three dimensions: the attributes of mandatory reporting; the population exposed to mandatory reporting; the types of effects produced by mandatory reporting (cognitive, attitudinal, behavioral); and unintentional effects. Data were collected via

abstract of BNE records, the BNE implementation study, and semi-structured interviews of BNE staff.

Research Question Two

Differences in the use of peer review as a process of accountability in assuring the quality of professional nursing practice was categorized and measured according to:

1. Effort - relating to BNE staff hours and organizational staff hours involved in peer review prior to as compared to after enactment of SB 1160. Data were collected by abstract of BNE records, semi-structured interviews of BNE staff, and the peer review questionnaire developed by the investigator.
2. Performance - relating to the number of peer review committees functioning prior to as compared to after enactment of SB 1160, in health care facilities that regularly employ 10 or more registered nurses. The peer review questionnaire was used to collect this data.
3. Adequacy of performance - relating to the number of peer reviews completed by peer review committees prior to as compared to after enactment of SB 1160, in regard to: the evaluation of professional nursing services; the qualifications of professional nurses; the quality of patient care rendered by professional

nurses; the merits of complaints concerning professional nurses and professional nursing care; determinations or recommendations regarding complaints, including: the accuracy of nursing assessments and observations; and appropriateness and quality of the care rendered by a professional nurse; and professional nurse reporting.

4. Efficiency - pertaining to determination of costs related to functioning of peer review committees within health-care facilities employing 10 or more registered nurses, prior to as compared to after enactment of SB 1160. Data were collected via the peer review questionnaire.
5. Process - according to four dimensions: attributes of peer review committees; the population exposed to peer review; situational context in which peer review occurs; and the types of effects produced by peer review, including unintentional effects. Data were collected via the peer review questionnaire.

Setting

This research was conducted in the State of Texas. Some categories of evaluation used to answer the research questions were tested via survey techniques of registered nurses within the State of Texas. Texas is a large state with approximately 116,570 registered nurses licensed in 1989 (BNE, 1990) and thousands of health care

organizations which were mandated to establish peer review committees. Registered nurses who serve on peer review committees were surveyed. The setting for peer review committees is specified in SB 1160 as:

> each hospital, nursing home, health science center, home health agency, other health-care facility, state agency, political subdivision, school of professional nursing, temporary nursing service, or person that regularly employs, hires, or otherwise contracts for the services of 10 or more registered nurses...(1987, p. 2266).

Additional data to test the categories of evaluation were obtained from records within the BNE's Austin office.

Population and Sample

The population for this study included all registered nurses within the State of Texas who were licensed with the BNE to practice professional nursing before enactment of SB 1160 (January 1, 1987 to December 31, 1987) and after enactment of SB 1160 (January 1, 1988 to December 31, 1989). The sample for the study was derived from this population and was obtained via probability and nonprobability sampling methodologies (Table 2).

The categories of effort, efficiency and process in the first research question were collected via convenience sampling. These categories of information were obtained from existing records maintained by the BNE and by interviews of key individuals involved in these processes.

Table 2

Sampling Methodology In Relation to Suchman's Categories of Evaluation

Category	Sampling Approach
Research Question One: How do professional and organizational accountability relating to professional nurse reporting differ prior to as compared to after the enactment of 1987 Texas SB 1160?	
1. Effort	Convenience
2. Performance	Simple random
3. Adequacy of Performance	Simple random
4. Efficiency	Convenience
5. Process	Convenience
Research Question Two: What are the differences in the use of peer review before as compared to after the enactment of 1987 Texas SB 1160?	
1. Effort	Simple random
2. Performance	Simple random
3. Adequacy of Performance	Simple random
4. Efficiency	Simple random
5. Process	Simple random

For research question one, the categories of performance and adequacy of performance consisted of a simple random sample of complaints to the BNE of professional nurses believed to be practicing below the acceptable standards of practice. One hundred complaints were randomly selected from each complaint log maintained by the BNE during 1987 (prior to enactment) and 1988-1989 (after enactment).

All categories of evaluation in the second research

question were collected via simple random sampling. This sample consisted of health care organizations within the State of Texas who employ registered nurses. A list of these organizations was obtained from the Texas Department of Health and the BNE. A total sample size of 1000 (N=1000) health care organizations were used. A sample size of 500 assures that the sampling error will not exceed a standard deviation of 10 about 98 percent of the time (Roscoe, 1975).

Protection of Human Subjects

This research complied with the rules and regulations of the Human Subjects Review Committees of Texas Woman's University and the BNE. The BNE formed a committee to develop policy and procedures for investigators to follow in conducting research regarding confidential information obtained by the Board. The Texas Attorney General's office collaborated with the BNE to assure protection of human subjects. The investigator followed the policies and procedures developed by the BNE after obtaining permission to conduct the study (Appendix D).

The study was exempt from full Human Subjects review at Texas Woman's University because it consists of survey research of adult subjects. Participants were informed that participation was voluntary and that confidentiality of records would be maintained.

A cover letter was developed by the investigator

to accompany the questionnaires. The letter included an explanation of the purpose and procedures to be followed in completing the questionnaires. Even though minimal discomfort or risk was expected to occur with such a questionnaire, the possibility was included in the letter along with potential benefits. Participants were provided an explanation of whom to contact for answers of pertinent questions about the questionnaire and participant rights.

Instruments

Research Question One

Professional and organizational accountability as related to professional nurse reporting were categorized and measured via:

1. Record abstracts of existing data sources maintained by the BNE. Coding forms developed by the investigator are included in Appendix E. These forms were used to collect data from three sources: BNE complaint log; disciplinary report forms filed by the BNE with the National Council of State Boards of Nursing; and BNE performance and funds management reports. Content validity was established by a panel of experts.
2. An interview guide was developed by the investigator for use in semi-structured interviews of BNE staff (Appendix F). Content validity was established by a

panel of experts. All interviews were conducted by the investigator. Anonymity was assured by assigning each participant a code number and in no way revealing the participant's name.

Research Question Two

Peer review as a process of accountability as designated by Suchman's categories of evaluation was collected by:

1. "The Peer Review Questionnaire" developed by the investigator. This questionnaire surveyed all five categories of evaluation as described by Suchman: effort, performance, adequacy of performance, efficiency, and process. A demographic data form (Appendix G) accompanied the instrument, which also provided data to evaluate Suchman's categories and allow the use of descriptive statistics in summarizing the findings.

   Demographic variables included: gender; age; type of organization; size, if an in-patient facility; number of years of nursing experience; major clinical practice area; position in nursing; highest education in nursing; highest education other than nursing; position on peer review committee; composition of committee members; number of members on the peer review committee; number of peer reviews conducted by the committee during 1987, 1988, and 1989; number of

peer reviews completed which resulted in a nurse being reported to the BNE during 1987, 1988, and 1989; number of peer reviews completed which resulted in a nurse being reported to the Texas Peer Assistance Program for Impaired Nurses (TPAPIN) in lieu of the BNE during 1987, 1988, and 1989; total number of hours per month the peer review committee was involved in peer review activities during 1987, 1988, and 1989; and the number of RNs currently employed by the organization, including full and part time. These variables were thought to be relevant to the research question. Most coincide with demographic variables identified in a study conducted by the BNE regarding the implementation of SB 1160. The BNE study is the only other study examining SB 1160.

"The Peer Review Questionnaire" is a self-administered, Likert-format scale (Appendix H). The Likert-format is based on the assumption that the overall score based on responses to the items reflects the variables being measured and thus provides a good measure of the variables (Babbie, 1973). Guidelines developed by the American Nurses Association (1988) and the BNE (1989) for peer review were used in designing the instrument. The BNE guidelines were designed for use in implementing SB 1160, Section 3, Article 4525b (Appendix I). A

blueprint of the questionnaire and demographic data form are provided (Appendix J).

Content validity was established by a panel of experts. The panel consisted of professional nurses who serve on peer review committees and/or have knowledge of regulatory requirements designated in SB 1160.

For purposes of establishing construct validity, point biserial correlations and factor analysis were performed on the dissertation data. All items were found to have a point biserial correlation greater than 0.3 and therefore subject to factor analysis. Factor analysis provided information about the extent to which the items measure the underlying construct of peer review.

Factor analysis was used to assess the extent to which the individual items converge around one or more dimensions (Woods, 1988) of the peer review process. Four factors were identified by the factor analysis. All factors had a minimum eigenvalue of 1.0 and explain at least five percent of the variance. These four factor accounted for 36.3% of the explained variance. To determine which items grouped together for a particular factor, the rotated factor matrix was examined. A factor loading score of .30 was the cutoff score for including an item in the

factor (Woods, 1988).

Factor 1 included seven items dealing with the adequacy of performance of peer review. Factor 2 included six items dealing with policies of the peer review committee (process). Factor 3 included six items dealing with procedures of peer review committees (process), and factor 4 included seven items dealing with structure and process components of peer review. Three items (questions 16, 18, and 29) loaded onto three factors and should be eliminated or restructured if the instrument were used again.

Reliability for the Peer Review Questionnaire was established during a pilot study of the instrument. A convenience sample of 36 registered nurses who served as chairpersons or members of a peer review committee within a health care organization located within Southeast Texas were selected. Sixteen nurses responded to the questionnaire, resulting in a 44% response rate. Internal consistency reliability was established using the alpha coefficient. The alpha coefficient for the Peer Review Questionnaire was .97 which denotes a high degree of internal consistency reliability. The questionnaire format was reorganized following the pilot study to facilitate completion by participants.

2. Record abstract of BNE data as described in question one.
3. Semi-structured interview guide as described in question one.

Table 3 summarizes the instruments utilized in conducting this research.

Table 3

Instruments In Relation to Suchman's Categories of Evaluation

Category	Instrument
Research Question One: How do professional and organizational accountability related to professional nurse reporting differ prior to as compared to after the enactment of 1987 Texas SB 1160?	
Effort Performance Adequacy of Performance Efficiency Process	Record abstract coding forms and interview guide
Research Question Two: What are the differences in the use of peer review before as compared to after enactment of 1987 Texas SB 1160?	
Effort Performance Adequacy of Performance Efficiency Process	Record abstract coding forms, interview guide, peer review questionnaire, and demographic data sheet

Data Collection

After obtaining permission from the Human Subjects Review Committee of Texas Woman's University and the BNE, an appointment was arranged with the Executive Secretary

of the BNE to develop a schedule for data collection. Record abstract and interviews were conducted as per arrangements with flexibility by the investigator to provide minimal disruption of BNE activities.

The Peer Review Questionnaire and demographic data form were accompanied by a cover letter (Appendix K). The cover letter served as an introduction to the study, stressing the importance and usefulness of the topic. Confidentiality was assured. The questionnaire was coded for follow-up. An addressed, stamped envelope was included for convenience in returning the questionnaire. To increase responsiveness a follow-up mailing was done at 5 weeks following the initial mailing.

Completion of the questionnaire implied informed consent to participate in the study. All instruments were administered by the investigator and kept in a locked cabinet throughout the study. The code sheets were kept in the locked cabinet with the questionnaires and destroyed upon completion of the study.

Treatment of Data

Data analysis was performed at Lamar University, Beaumont with onsite computer facilities. The SPSSx information analysis system was used with mainframe capabilities. Statistical consultation was provided by Lamar University and Texas Woman's Uiversity.

After the data were collected from participants, it

was prepared for analysis: edited for legibility and completeness, then coded and transferred to a computer file. Descriptive statistics were used including central tendency, variability, and correlation. Central tendency allows the investigator to ascertain the location of the distribution or the most typical values in the distribution (Woods, 1988). Variability describes the dispersion of values in the distribution. Descriptive statistics allow the organization and presentation of data in a convenient, usable and communicable form (Runyon & Habor, 1980).

Research Question One

Descriptive statistics were used to describe the differences between professional nurse reporting as a process of accountability prior to as compared to after enactment of SB 1160. Data collected via the interview guide to answer research question 1 were coded using inductively generated codes. Babbie (1973) describes this method as appropriate whenever the investigator is not sure initially how the data should be coded.

Research Question Two

The categories of effort, performance and adequacy of performance, efficiency and process in relation to the use of peer review before as compared to after enactment of SB 1160 yielded nominal, interval and ratio level data.

An analysis of group difference using a t-test for related and independent samples was used. A two-tailed test of significance with alpha set at .05 was used. The use of inferential statistics, such as the t-test allows the investigator to make inferences from the sample to a larger population (Woods, 1988).

Correlation coefficients were also employed with the data generated from research question 2. Correlation examines the relationship among variables. Spearman rho correlation coefficients were utilized since the variables correlated represented ordinal leval data. Table 4 provides a summary of the treatment of the data.

Table 4

Analysis

Variable	Level of Data	Statistical Test
Research Question 1: Professional Nurse Reporting	Nominal Interval/Ratio	Descriptive stats
Research Question 2: Peer Review	Nominal Ordinal Interval/Ratio	Descriptive stats Correlation t-test

CHAPTER 4

ANALYSIS OF DATA

In this chapter, a description of the sample and results of the data analysis are provided. The sample is described in terms of gender, age, place of employment in nursing, number of years nursing experience, major clinical practice area, position in nursing, highest education in nursing, highest education in area other than nursing, and position on peer review committee. The presentation of findings is organized according to the two research questions. Each question is categorized according to Suchman's (1967) categories for evaluation.

Description of Sample

In examining peer review as a process of accountability, 1000 nurses were surveyed. Four hundred fifty two (452) nurses responded to the Peer Review Questionnaire, resulting in a 45% response rate. Of this group, 96 respondents indicated that their organizations employ less than 10 RNs and are therefore not required to have a peer review process. Forty-four respondents indicated that, even though their organization employed 10 or more RNs, no peer review process existed. The final response rate was therefore 312 completed questionnaires. An additional 72 nurse respondents

indicated that they did not wish to participate in the survey.

The description of the demographic data will be divided into two groups. The largest group of respondents (N=312) were those who completed at least Part 2 (indicating that a structure for a peer review process existed) or Parts 2 & 3 (indicating that a structure existed and had been utilized in conducting a peer review). This group will be referred to as Group 1. Group 2 will include those respondents whose organization employed 10 or more RNs, yet failed to have a peer review process (N=44).

Gender

The predominant gender of both groups was female. For the total sample, 333 (93.5%) were female while 20 (5.6%) were male. Of Group 1, 309 (99%) responded to the question on gender, 290 (93.9%) were female and 19 (6.1%) were male. Group 2 consisted of 43 (97.7%) females and one (2.3%) male.

Age

Over two-fifths (129; 41.3%) of the respondents in Group 1 categorized themselves in the 41-50 year range. The largest number of respondents (17; 38.6%) in Group 2 were in the 31-40 year range (Table 5).

Table 5

Ages of Group 1 and Group 2

Age (Years)	Group 1 n	Group 1 %	Group 2 n	Group 2 %
20-30	6	1.9	6	13.6
31-40	103	33.0	17	38.6
41-50	129	41.3	16	36.4
51-60	56	17.9	4	9.1
> than 60	15	4.8	1	2.3
No Response	3	1.0	0	0.0
Total	312	100.0	44	100.0

Place of Employment in Nursing

The largest number of respondents in both groups (203, 57%) were employed by acute care hospitals. In Group 1, 185 (59.3%) were employed in acute care hospitals, whereas 18 (40.9%) of Group 2 were employed in acute care hospitals. Many of the respondents in both groups (55; 15.4%) were unable to classify their place of employment within the seven categories provided and selected "other." Forty-five (14.4%) respondents in Group 1 selected "other." These responses included psychiatric hospital (19; 6%), rehabilitation center (6; 1.9%), corrections (1; 0.3%), mental health/mental retardation centers (13; 4.1%), long term care facilities (2; 0.6%), college of medicine (1; 0.3%), public school district (1; 0.3%), consulting agency (1; 0.3%), and state department of health

agency (1; 0.3%). Even a larger percentage (10; 22.7%) of Group 2 selected "other" which included crisis stabilization unit (1; 2.3%), free standing dialysis center (3; 6.8%), psychiatric hospital (3; 6.8%), neurological development center (1; 2.3%), and rehabilitation hospital (2; 4.5%). Table 6 describes the frequencies and percentages of respondents place of employment in nursing.

If the employing organization was an in-patient facility, respondents were ask to identify the size of the institution according to number of beds. Table 7 describes size of employing agency.

Table 6

Place of Employment in Nursing

Employing Agency	Group 1 n	%	Group 2 n	%
Acute Care Hospital	185	59.3	18	40.9
Nursing Home/Extended Care	3	1.0	1	2.3
School of Nursing	37	11.9	3	6.8
Freestanding Clinic	0	0.0	1	2.3
Community/Public Health	15	4.8	6	13.6
Home Health Agency	15	4.8	3	6.8
Nursing Agency	9	2.9	2	4.5
Other	45	14.4	10	22.7
No Response	3	1.0	0	0.0
Total	312	100.0	44	100.0

Table 7

Size of Employing Agency, If An In-Patient Facility

Size*	Group 1 n	Group 1 %	Group 2 n	Group 2 %
Not Applicable	85	27.2	15	34.1
< than 50	35	11.2	12	27.3
50-99	52	16.7	8	18.2
100-199	54	17.3	6	13.6
200-399	54	17.3	1	2.3
400-599	18	5.8	2	4.5
600 or more	11	3.5	0	0.0
No response	3	1.0	0	0.0
Total	312	100.0	44	100.0

*number of beds

Number of Years Nursing Experience

More than a third of respondents in Group 1 (131; 42%) and Group 2 (15; 34.1%) had more than twenty years nursing experience. Overall, the respondents had substantial experience in nursing (Table 8).

Table 8

Number of Years Nursing Experience

Years	Group 1 n	Group 1 %	Group 2 n	Group 2 %
Less than 1 year	0	0.0	1	2.3
1-5 years	4	1.3	1	2.3
6-10 years	17	5.4	10	22.7
11-15 years	76	24.4	8	18.2
16-20 years	80	25.6	9	20.5
more than 20 years	131	42.0	15	34.1
Total	312	100.0	44	100.0

Major Clinical Practice Area

Medical-surgical nursing was the major clinical practice area for over one-third of the respondents in both groups (Table 9). Many nurses had difficulty classifing their practice area into one of the four provided categories and therefore selected "other." In Group 1, administration was listed by 26 (8.3%) of the respondents and critical care by 25 (8%) of the respondents. Other practice areas specified by Group 1 included quality assurance/risk management (13; 4.1%), education (7; 2.2%), operating room (4; 1.2%), mental health/mental retardation (4; 1.2%), rehabilitation (4; 1.2%), home health (3; 0.9%), oncology (2; 0.6%), orthopaedics (1; 0.3%), and patient advocate (1; 0.3%). Group 2 listed critical care (4; 9%), home health (3; 6.8%), geriatrics (2; 4.5%), nephrology (1; 2.3%), quality assurance (1; 2.3%), and mental retardation (1; 2.3%).

Table 9

Major Clinical Practice Area

Clinical Area	Group 1 n	Group 1 %	Group 2 n	Group 2 %
Community/Public Health	30	9.6	7	15.9
Maternal/Child Health	31	9.9	4	9.1
Medical/Surgical	104	33.3	14	31.8
Psychiatric/Mental Health	49	15.7	7	15.9
Other	90	28.8	12	27.3
No Response	8	2.6	0	0.0
Total	312	100.0	44	100.0

Position in Nursing

The majority of respondents in the total group (195; 62.5%) and both Group 1 (164; 52.6%) and Group 2 (31; 70%) were nurse administrators (Table 10). Nurse managers comprised the second largest number for the total group (56; 15.7%) and both Group 1 (50; 16%) and Group 2 (6; 13.6%). Thirty-eight (38; 12.2%) respondents in Group 1 selected "other." Of these, quality assurance/risk management was identified by 16 (5%). Nine (2.8%) respondents identified themselves as the director of nursing and six (1.9%) as administrator. Other positions identified by Group 1 respondents were supervisor (4; 1.2%), patient advocate (1; 0.3%), special projects coordinator (1; 0.3%), and administrative associate with joint faculty appointment (1; 0.3%). Three (6.8%) respondents in Group 2 selected

"other": one (2.3%) director of nursing, one (2.3%) director of human resources, and one (2.3%) assistant manager.

Table 10

Position in Nursing

Position	Group 1 n	Group 1 %	Group 2 n	Group 2 %
Staff Nurse	5	1.6	1	2.3
Nursing Manager	50	16.0	6	13.6
Nursing Administrator	164	52.6	31	70.5
Nurse Educator	46	14.7	3	6.8
Clinical Nurse Specialist	6	1.9	0	0.0
Nurse Practioner	0	0.0	0	0.0
Other	38	12.2	3	6.8
No Response	3	1.0	0	0.0
Total	312	100.0	44	100.0

Highest Education

Over one-third of the respondents in the total groups (126; 35.4%) and both Group 1 (105; 33.7%) and Group 2 (31; 70.5%) had a bachelor's degree in nursing (Table 11). A large number of the respondents in Group 1 (136; 43.5%) and Group 2 (17; 38.6%) held additional degrees other than nursing (Table 12).

Table 11

Highest Education in Nursing

Type	Group 1 n	Group 1 %	Group 2 n	Group 2 %
Diploma	49	15.7	7	15.9
Associate Degree	47	15.1	9	20.5
Bachelor's Degree	105	33.7	21	47.7
Master's Degree	97	31.1	4	9.1
Doctoral Degree	8	2.6	0	0.0
No Response	6	1.9	2	4.6
Total	312	100.0	44	100.0

Table 12

Highest Education in Area Other than Nursing

Type	Group 1 n	Group 1 %	Group 2 n	Group 2 %
None	176	56.4	27	61.4
Associate Degree	25	8.0	4	9.1
Bachelor's Degree	51	16.3	9	20.5
Master's Degree	40	12.8	3	6.8
Doctoral Degree	16	5.1	0	0.0
No Response	4	1.3	0	0.0
Total	312	100.0	44	100.0

Position on Peer Review Committee

Only the respondents in Group 1 replied to this question since Group 2 respondents had no peer review committee. The majority (161; 51.6%) of the respondents in Group 1 were the chairperson of their peer review

committees. Sixty six (21.2%) of the respondents were members of the committee. Another 69 (22.1%) selected "other," while 16 (5.1%) failed to respond. The most frequently identified position under "other" was that of director of nursing/administrator (24; 7.6%). Seventeen (5.4%) respondents identified themselves as committee advisor/facilitator, eleven (3.5%) as ex-officio members, eight (2.6%) as ad hoc members, seven (2.2%) as non-voting members, one (0.3%) consultant and one (0.3%) co-chairperson.

Findings

The findings for each research question will be presented according to Suchman's (1967) categories of evaluation. Research question one addresses professional and organizational accountability (dependent variables) related to professional nurse reporting (independent variable). Research question two addresses professional and organizational accountability (dependent variables) related to the use of peer review (independent variable).

Research Question One

How do professional and organizational accountability relating to professional nurse reporting differ prior to as compared to after the enactment of 1987 Texas SB 1160? Professional and organizational accountability related to professional nurse reporting

were categorized and measured according to Suchman's categories for evaluation.

The first variable was effort which pertained to BNE staff hours in handling professional nurse reporting prior to as compared to after enactment of SB 1160. Although the BNE kept no specific record of staff hours related to professional nurse reporting, an indirect measure would be the increase in staffing required following SB 1160. Prior to SB 1160, the BNE conducted a limited number of on-site (field) investigations of complaints regarding professional nurses (BNE staff interview). However, SB 1160 provided appropriations for additional staff and investigators. Prior to SB 1160, the investigations staff consisted of two investigators and one secretary. During 1988, eight additional staff members were hired, including five investigators and three support persons. The 1989 legislative session authorized one additional support person and one attorney. The need for these additional staff were justified by the BNE as a result of "the significant increase in the number of complaints received" (BNE Performance & Funds Management Report, 1988).

Effort was expended by the BNE in conducting workshops for the purpose of informing nurses, employers, the public, and others of pertinent law and rule changes and of the work of the board. Three (3) workshops were conducted by the BNE in 1987, two (2) during 1988, and

four (4) during 1989 (BNE Performance & Funds Management Reports). During October 1989, the BNE began an extensive educational program concerning peer review and mandatory reporting, in which twelve workshops were planned for presentation across the state of Texas (BNE staff interview).

SB 1160 required the BNE to disseminate at least twice a year information that is of significant interest to nurses and employers in relation to peer review and mandatory reporting. It also required information to include summaries of final disciplinary action taken by the BNE. This mandate is accomplished via the BNE newsletter. During 1987, the BNE published four (4) newsletters which were distributed to 1162 nurses and employers (BNE Performance & Funds Management Report, 1987). With the implementation of SB 1160, three (3) newsletters were published during 1988 and distributed to 144,532 nurses and employers (BNE Performance & Funds Management Report, 1988). In 1989, four (4) newsletters were published with a total distribution of 139,690 (BNE Performance & Funds Management Report, 1989). The increase in distribution was directly related to BNE effort to inform all RNs of the changes in the Nurse Practice Act as related to SB 1160 and to provide summaries of final disciplinary actions taken by the BNE.

The second variable, performance, related to yield of complaints regarding professional nurses prior to as compared to after enactment of SB 1160. BNE Performance and Funds Management Reports for fiscal year 1987, 1988, and 1989 were reviewed to obtain this data. The use of fiscal year data corresponds to the implementation of mandatory reporting which became effective during September, 1987. Therefore, fiscal year 1987 accurately reflects a one year period prior to the implementation of mandatory reporting. Table 13 includes the number of professional nurses licensed in Texas during 1987, 1988, and 1989. It also includes the number of professional nurse complaints received prior to and after SB 1160 and the percentage of the RN population represented by these complaints.

Table 13

Number of Professional Nurse Complaints in Relation to Total RN Population Prior To and After SB 1160

Year	RNs Licensed n	Complaints n	Proportion of RN Population %
1987	109,457	452	0.4
1988	111,728	832	0.7
1989	116,570	954	0.8

The third variable, adequacy of performance, related to the disposition of complaints received from professional nurse reporting prior to and after SB 1160. Abstracts of BNE Performance and Funds Management Reports provided information that directly related to the adequacy of performance of professional nurse reporting (Table 14). The BNE Performance and Funds Management Reports also consisted of general statements by the BNE administrator in regard to the performance values. Two statements pertained to performance values described in Table 14. During 1988, it was noted by the administrator that SB 1160 had resulted in "a significant increase in the number of complaints received; the number of disciplinary hearings before the board; the number of licenses revoked, suspended or probated; and the number of nurses monitored by the board after disciplinary action" (p. 3). During 1989, the average time for complaint resolution was longer than anticipated due to:

> (1) the complex nature of the complaints, (2) the frequent involvement of the nurse's legal counsel in a complaint investigation, and (3) the inexperience of the board's newly hired investigators. Because of the complex nature of practice-related complaints, the number of on-site investigations was greater than projected. (p. 3)

Table 14

Adequacy of Performance of Professional Nurse Reporting Prior To and After SB 1160

Performance Measure	Value During Year 1987	1988	1989
Number of Written Complaints Received	452	832	954
Number of Complaints Resolved	*	604	708
Average Number of Days for Complaint Resolution	*	72	135
Number of Investigations	446	699	712
Number of Field Investigations	6	98	307
Number of Investigations by Phone/Mail	440	601	405
Number of Informal Disciplinary Hearings	84	57	134
Number of Formal Disciplinary Hearings	87	117	76
Total Number of Disciplinary Hearings	171	174	210
Number of Hearings Resulting in Disciplinary Action	167	116	153
Number of Licenses Monitored	429	603	669

* Value not available

Record abstracts from disciplinary reports filed by the BNE with the National Council of State Boards of Nursing (NCSB) also provided information regarding the adequacy of performance of professional nurse reporting.

The reports filed during 1987, prior to SB 1160, were not available to the investigator. During 1987, 134 disciplinary reports were filed with the NCSB. The number of reports increased to 141 during 1988 and to 165 during 1989.

Table 15 includes the types of disciplinary action taken by the BNE against violators of the nurse practice act. Of the 50 reports reviewed by the investigator during 1988, 13 (26%) of the violators were men and 37 (74%) were female. During 1989, review of 50 reports revealed that 12 (24%) violators were male and 38 (76%) were female. Case descriptions provided examples of cases where nurses violated the practice act, were reported to the BNE, and received diciplinary action (Table 16).

Table 15

Types of Disciplinary Action Taken as Reported to NCSB as an Indicator of Adequacy of Performance

Type of Action Taken	Year 1988* n	%	1989* n	%
Licensure Denied	1	2.0	0	0.0
Licensure Limited	0	0.0	0	0.0
Licensure Revoked	26	52.0	10	20.0
Voluntary Surrender	5	10.0	0	0.0
Suspension	13	26.0	22	44.0
Probation	21	42.0	33	66.0
Fine	0	0.0	0	0.0
Reprimand	4	8.0	17	34.0
Other	6	12.0	3	6.0

*n= 50

Table 16

Case Descriptors as Reported to the NCSB as an Indicator of Adequacy of Performance

Descriptor+	Year 1988* n	1988* %	1989* n	1989* %
Drugs	13	26.0	10	20.0
Abuse	10	20.0	8	16.0
Diversion	5	10.0	1	2.0
Self Administration	6	12.0	6	12.0
Use on Duty	2	4.0	0	0.0
Other	1	2.0	5	10.0
Inconsistent Nursing Practice	4	8.0	12	24.0
Leaving Duty Station	0	0.0	1	2.0
Failure to Maintain Minimum Standards	0	0.0	6	12.0
Incompetent Practice	2	4.0	1	2.0
Other	2	4.0	11	22.0
Administering Medications	15	30.0	23	46.0
Failure to Follow Medical Orders	8	16.0	14	28.0
Failure to Have Wastage Witnessed	3	6.0	1	2.0
Failure to Document Administration	5	10.0	7	14.0
Other	3	6.0	9	18.0
Misconduct	10	20.0	3	6.0
Fradulent Practice	2	4.0	1	2.0
Other	8	16.0	5	10.0
Conviction of	13	26.0	9	18.0
Felony	1	2.0	2	4.0
Action Taken In Another Jurisdiction	12	24.0	7	14.0

*n= 50

+Some cases had more than one category of descriptor

Case descriptors identified as "other" drugs include: during 1988, giving and/or attempting to sell medication; and during 1989, appropriating, use of alcohol, and failure to comply with previous board order. In relation to inconsistent nursing practice, two "others" were identified during 1988, failure to adequately assess a patient and charting care not provided. "Other" inconsistent nursing practice described during 1989 (11) were: failure to notify the physician of patient's change in condition (3); administered blood to the wrong patient; reported for duty unfit to practice by reason of mental/physical health; failed to document vital signs (2); attempted to infuse fresh frozen plasma into same intravenous line with Dopamine; failed to respond to request for assistance in the emergency transfer of a critically ill patient; failed to restart intravenous fluids on an infant; and prepped wrong extremity, failed to document closing sponge count of operative procedure, failed to correct error on operative permit.

Descriptors identified as "other" under administering medications during 1988 included: made false entries in narcotic records (2), and signing out medication without physician's order. Nine were identified during 1989, which included: administered medication into arterial line of patient; failed to assess patient in distress; administered Lidocaine

without physician's order; made false entries in records; increased rate of intravenous fluid without physician's order; failed to properly document an error; altered a physician's order for medication (2); and failed to check placement of feeding tube prior to administration.

Failure to comply with previous board order was identified as "other" misconduct eight (8) times during 1988 and three (3) times during 1989. Also identified during 1989 as "other" misconduct were: falsifying nursing assessments and the provisions of patient care in medical records, and falsified application for employment.

The fourth variable, efficiency, represents estimates of cost expended by the BNE in relation to adequacy of performance of professional nurse reporting prior to as compared to after enactment of SB 1160. The fiscal note attached to SB 1160 provided the legal basis for an appropriation of funds to the BNE to implement the provisions of the bill. Table 17 includes the projected cost by the Legislative Budget Board (1987) for implementation of SB 1160 and the actual funds appropriated to the BNE for implementation of the bill. Appropriations were primarily for professional nurse reporting, although BNE costs for educational programs for peer review were included.

Table 17

Projected & Actual Appropriations of Funds to Implement SB 1160

Fiscal Year	Projected Cost	Actual Appropriation
1988	$626,591.	$246,300.
1989	$550,156.	$324,257.
1990	$550,156.	*

*included in program administration

Other indicators of efficiency of professional nurse reporting are the average cost of a formal disciplinary hearing reported in the BNE Performance and Funds Management Reports. The average cost of a formal disciplinary hearing during 1987 was $565. This cost decreased to $475 during 1988. However, it should be noted that the average cost of a disciplinary hearing was redefined during 1988. Prior to 1988, the figure included cost of doing the investigations as well as the cost of the disciplinary hearing. Following the redefinition, the costs of investigations were separately reported (BNE Performance & Funds Management Report, 1988). During 1989, the BNE reported the average cost of a formal disciplinary hearing as $495 and the average cost of a field investigation as $122. The cost of field investigations was not reported prior to 1989.

The fifth variable, process, has four dimensions: the attributes of mandatory reporting; the population

exposed to mandatory reporting; the types of effects produced by mandatory reporting; and unintentional effects.

An abstract of BNE complaint logs was derived to determine the types of complaints being received (attributes of mandatory reporting). Complaints are identified according to which article of the Nurse Practice Act the nurse is suspected of violating. Article 4525 of the Texas Statutes Regulating the Practice of Professional Nursing (1989) describes disciplinary proceedings in which action can be taken against a professional nurse. Table 18 describes 200 complaints logged during 1987, 1988, and 1989. Reports of unprofessional conduct relate to any act, practice, or omission that fails to conform to the accepted standards of the nursing profession. These complaints are specifically related to professional nursing practice.

Table 18

Suspected Violations of the Nurse Practice Act Prior To and After SB 1160*

Suspected Violation	Year 1987 n	%	1988 n	%	1989 n	%
Unprofessional Conduct	67	33.5	115	57.5	126	63.0
Expired License/ Licensure with Conditions	62	31.0	39	19.5	30	15.0
Substance Abuse	38	19.0	28	14.0	24	12.0
Action by Another State Nursing Board	26	13.0	16	8.1	11	5.6
RN Imposter	7	3.5	2	1.0	2	1.0
Noncompliance with a Board Order	5	2.5	7	3.5	11	5.6
Lack of Mental Fitness	4	2.0	7	3.5	11	5.5
Criminal Conviction	1	0.5	1	0.5	3	1.5

*Some complainants reported more than one violation per report (n= 200 per year)

The population exposed to mandatory reporting relates to the type of complainant filing the complaint. SB 1160 mandated reporting of suspected violations of the Nurse Practice Act by: RNs, peer review committees, organizations, professional associations, state agencies that survey health care facilities, insurance companies, and law enforcement agencies. Table 19 includes the type of complainants reporting the suspected violations of the Nurse Practice Act described in Table 18. Prior to SB

1160 (1987) the BNE did not record the type of complainant.

Table 19

Types of Complainants Filing Reports of Suspected Violations of the Nurse Practice Act

Type of Complainant	Year 1988 n	1988 %	1989 n	1989 %
Peer Review Committee *	62	31.0	75	37.5
Hospital	25	12.5	10	5.0
Nursing Home	1	0.5	1	0.5
Nursing Agency	2	1.0	3	1.5
State Agency	11	5.5	16	8.0
School of Nursing	0	0.0	1	0.5
Professional Association	0	0.0	1	0.5
Insurance Company	32	16.0	12	6.0
Court Conviction	0	0.0	1	0.5
General Public	6	3.0	12	6.0
TPAPIN	34	17.0	27	13.5
Other Jurisdiction	3	1.5	4	2.0
Law Agency	3	1.5	3	1.5
BNE	15	7.5	28	14.0
Other	6	3.0	6	3.0
Total	200	100.0	200	100.0

* Report may be filed by RN, other practitioner, or administrator

Interviews with BNE staff provided information about the types of effects produced by mandatory reporting, including unintentional effects. The primary effect was the large increase in the number of reports of suspected violations of the Nurse Practice Act. Prior to SB 1160 the majority of complaints were drug and

alcohol related, while few were practice related (BNE staff interview). The number of practice related complaints has significantly increased. According to BNE staff, a very positive effect of the bill has been to assist the BNE to enforce the provisions of the nurse practice act.

Prior to SB 1160, most of the complaints received were from employers. However, following SB 1160 reports from employers and others increased (BNE staff interview). A large number of organizations are "now reporting, possibly even over reporting" (BNE staff interview). This increase in reports has occurred especially in relation to "medication errors" (BNE staff interview). Since most medication errors subject client to risk of harm, organizations have difficulty determining when a medication error is reportable. However, the BNE mission is to protect the public, therefore, the BNE staff report preferring over reporting to under reporting.

As a result of the increase in complaints, the BNE developed two types of informal hearings (BNE staff interview). A prehearing conference with agreed orders (consent hearing) is available. This type of informal hearing includes the nurse, legal counsel, executive secretary, and the Director of Practice and Compliance. Approximately 75% of the cases are now being resolved

in prehearings (BNE staff interview). Informal hearings, which include the nurse, executive secretary and investigator, are also available. All nurses not satisfied with an informal hearing can request a formal hearing before the board.

"A ripple effect" on organizational operation of the BNE has occurred as a result of SB 1160 (BNE staff interview). Primarily as a result of mandatory reporting, an increased workload has been imposed on numerous departments within the BNE. During 1990, the BNE has reorganized its Investigations & Enforcement Department to become the Practice & Compliance Department. This new departmental organization will provide education, via nurse consultants, regarding nursing practice issues in addition to monitoring compliance with the Nurse Practice Act (BNE staff interview). This reorganization reflects the emphasis by the BNE on practice related issues and the need for education created by SB 1160.

Other unnintentional or unexpected effects of mandatory reporting on the BNE have resulted in "a strain on resources" (BNE staff interview). This strain has occurred particularly in relation to the BNE's information and management systems (computer). The BNE discovered that their computer capacity was limited in handling the increase in workload. A new computer system was obtained, which is already being quickly

outgrown (BNE staff interview).

Research Question Two

What are the differences in the use of peer review before as compared to after the enactment of 1987 Texas SB 1160? Differences in the use of peer review as a process of accountability prior to and after SB 1160 are categorized according to Suchman's categories for evaluation.

The first category, effort, related to BNE staff hours and organizational staff hours involved in peer review prior to as compared to after enactment of SB 1160.

BNE Staff Hours: Prior to SB 1160 the BNE expended no effort on peer review activities, except in preparing for the legislative session. Effort expended by the BNE in peer review arises primarily from preparation and presentation of information regarding peer review implementation. The BNE included in its newsletter information regarding the implementation of peer review. In addition, 20 presentations were presented throughout the state to educate nurses and organizations concerning the implementation of peer review. The BNE developed its own set of guidelines for written peer review plans in professional schools. They also monitored the implementation of those guidelines in professional nursing schools since the BNE has regulatory power over those institutions. Four BNE staff were involved in the extensive implementation study undertaken by the BNE

during 1988, which included peer review. In addition, a nine member nursing advisory committee guided and assisted the BNE in this implementation study. The BNE maintained no specific record of the number of staff hours involved in peer review following passage of SB 1160, however it is obvious that a substantial number of hours were expended by BNE staff.

Organizational staff hours: Respondents to the Peer Review questionnaire were asked to specify an estimate of how many total hours (including all members) per month the peer review committee was involved in peer review activities. The number of hours were specified for 1987, 1988, and 1989 (Table 20).

Table 20

Total Hours Per Month Organizations Spent In Peer Review Activities*

Total Hours	Year 1987 n	1987 %	1988 n	1988 %	1989 n	1989 %
Zero	273	87.5	192	61.5	116	37.2
1-10 hours	23	7.3	80	25.9	128	40.9
11-20 hours	5	1.5	16	5.1	28	8.9
21-30 hours	1	.3	4	1.3	10	3.1
31-40 hours	2	.6	6	1.9	7	2.2
> 40 hours	2	.6	7	2.2	10	3.0
No response	6	1.9	7	2.2	13	4.2
Total	312	100.0	312	100.0	312	100.0

*Including all committee members

The mean number of total hours per month spent per organization prior to SB 1160, during 1987, was 1.7 hours

with a standard deviation of 12.36. During 1988, the mean rose to 4.9 hours with a standard deviation of 14.15. The mean increased even further during 1989 to 7.78 hours with a standard deviation of 19.18. A large number of organizations reported zero hours of involvement in peer review activities during 1988 (192; 61.5%) and 1989 (116; 37%), yet all completed Part 2, "After" responses of the questionnaire. This response most likely indicates that a written policy for peer review existed, however, the process had not been implemented.

The second category, process, is discussed according to four dimensions: attributes of peer review committees; the population exposed to peer review; the situational context in which peer review occurs; and the types of effects produced by peer review, including unintentional effects.

Part 2 of the Peer Review Questionnaire deals with the process dimensions of peer review. Part 2 is composed of a rating scale that ranged from "Strongly Disagree" (1) to "Strongly Agree" (5). Each statement could be responded to in relation to either prior to or after enactment of SB 1160 or both. All respondents in Group 1 (312) completed some portion of Part 2, either the prior and after responses or only the after responses. Table 21 includes the mean ratings of the peer review process in relation to Part 2, items 1-22 of the questionnaire.

Table 21

Mean Ratings of the Process Dimensions of Peer Review Prior To and After SB 1160

Descriptors	Prior n	Prior Mean	After n	After Mean
Committee members have an equal vote	172	3.59	308	4.66
Standards of practice are used to evaluate nursing care	180	3.95	309	4.52
RNs are reviewed by individuals of the same rank *	179	3.33	309	3.95
Peer review focuses on RNs practice decisions	176	3.61	309	4.52
A written plan exists for identifying and reporting RNs *	178	2.93	308	4.13
The committe is composed of a majority of RNs *	176	3.58	308	4.33
Purposes, functions, policies & procedures of committee are written *	178	3.08	310	4.44
Peer review is used to promote & improve care	178	3.49	308	4.13
A request for peer review may be initiated by any healthcare provider or patient	176	3.38	308	4.15
A RN would be reported to the BNE for conscious disregard of patient safety *	178	3.01	309	3.73
Committee offers commendation &/or constructive criticism of nursing care performance	175	3.06	308	3.69

Table 21 (Continued)

Descriptors	Prior n	Prior Mean	After n	After Mean
Institution/agency assumes cost of staff participation in the peer review process	176	3.75	310	4.44
The committee is democratically elected by the total RN group *	176	2.55	309	2.55
The committee is not a disciplinary committee *	178	3.34	310	3.78
Committee members represent various nursing specialties & positions *	176	3.50	310	4.14
Parliamentary procedure is followed during meetings *	174	3.44	309	3.89
The committee determines if patients receive adequate nursing care & if standards were met	175	3.43	307	4.09
BNE Standards of Nursing Practice & Unprofessional Conduct are used as a guide	178	3.58	312	4.57
RNs being reviewed are permitted to submit a written rebuttal *	176	3.85	312	4.63
Any RN being reviewed would not be reported to the BNE *	174	3.85	311	4.05
The committee is concerned with the qualifications of RNs being reviewed *	175	3.75	309	4.07
RNs being reviewed are given opportunities for meeting with the committee *	174	3.82	311	4.47

*Indicates the item was reverse-scored during data analysis.

The attribute of size was examined by asking respondents the number of members on the peer review committee. The number of nurse members and non-nurse members were specified (Table 22). The mean number of nurse members was 6.19 (n=312) with a standard deviation of 2.91. The mean number of non-nurse members was .56 (n=312) with a standard deviation of 6.07.

To assist in determining the situational context in which peer review occurs and the population exposed to peer review, respondents were asked to specify the composition of committees (Table 23). Many respondents (108; 34.6%) specified their peer review committee had "other" types of members than the five categories provided. The largest group of respondents (23; 7.4%) identified quality assurance/risk managers as members. Personnel/human resource directors (18; 5.8%) and health care administrators (16; 5.1%) comprised the next largest groups. Educators/clinical nurse specialists (12; 3.8%), directors of medical records (8; 2.6%), and attorneys (7; 2.3%) were also identified as "other" types of members. Various types of non-nursing health care provider members were identified: psychologists (3; 0.9%), lab technicians (2; 0.6%), dieticians (2; 0.6%), pharmacists (2; 0.6%), respiratory therapists (1; 0.3%), and social workers (1; 0.3%). Nursing related members identified included RN consultants (3; 0.9%), certified registered nurse

anesthetists (1; 0.3%), patient care advocates (1; 0.3%), and nurse's aides (1; 0.3%). Some organizations had committee members from outside the organization such as: consumers/lay persons (5; 1.6%) and RN reviewers from another health care facility (3; 0.9%). Other types of committee members identified were secretary/recorder (4; 1.2%), deans (2; 0.6%), chaplains (2; 0.6%), and board members (2; 0.6%). One respondent stated that the committee composition is determined by the employee under review, and another stated that members are appointed by the Vice President of Nursing as needed.

Table 22

Frequencies & Percentages of Nurse and Non-Nurse Peer Review Committee Members

Number of Members	Nurse Members n	Nurse Members %	Non-Nurse Members n	Non-Nurse Members %
Zero	0	0.0	198	63.5
1	0	0.0	67	21.5
2	1	0.3	32	10.3
3	25	8.0	2	0.6
4	39	12.5	2	0.6
5	80	25.6	2	0.6
6	53	17.0	0	0.0
7	33	10.6	0	0.0
8	23	7.4	0	0.0
9	13	4.2	0	0.0
10	9	2.9	0	0.0
> 10	19	6.0	0	0.0
No Response	17	5.4	9	2.9
Total	312	100.0	312	100.0

Table 23

Composition of Peer Review Committee Members*

Type of Member+	n	%
Nurse Administrators	146	47.4
Nurse Managers	186	60.4
Staff RNs	255	82.7
RN Faculty Members	51	16.6
Staff LVNs	70	22.7
Other	108	35.1

*N=308
+Respondents were able to choose multiple types of members.

Also, in relation to the population exposed to peer review, respondents were asked to rank order the types of behaviors their committee may have dealt with in the peer review process. A rating scale was used that ranged from most often encountered (1) to least often encountered (4). Almost half (153, 49%) of the respondents failed to answer the question. Sixty-six (41.5 valid %) rated failure to conform to the minimum standards of acceptable professional nursing practice as the most often encountered behavior. Fifty (31.3 valid %) rated failure to care adequately for a patient as the second most often encountered behavior. Unprofessional conduct was ranked as the third most often encountered behavior by 62 (40.5 valid %) of the respondents. The least often encountered behavior was impaired status, ranked fourth by 80 (50.6 valid %) respondents.

A section of the Peer Review Questionnaire allowed the respondents to write comments. Unintentional effects of peer review were addressed in this comment section. One respondent noted that peer review was greatly resented by those undergoing the process and another stated that the peer review process resulted in anxiety for all involved. Another respondent stated that peer review had been used for intimidation and harassment rather than for its intended use, promoting quality health care.

Other unintentional effects of peer review were identified by the BNE. The BNE identified "conflicting messages in the statute regarding the committees right to impose discipline" (BNE, personal communication, July 25, 1990). Article 4525b, Section (2), defined peer review but failed to identify any authority to discipline the nurse under review. It also stated that the review by the committee was only advisory and did not subject an employer's decision to discipline. Section (3) (c) stated that the committee itself may take disciplinary action against the nurse. The BNE planned to seek clarification of these issues in a future legislative session.

Another unintentional effect, as identified by the BNE, was that the peer review process appeared to be largely unregulated. According to the BNE Tenative Plans

for the 72nd Legislature (1990):

> When the legislation was written, an assumption was made that since the Texas Department of Health regulates health care facilities, they would enforce compliance with peer review legislation. We have been told that hospitals who are accredited by JCAH are deemed to meet the standard for Medicare participation. The Health Facilities Licensure and Certification Division of the Health Department conducts investigations as authorized by the Health Care Finance Administration. Currently, the Health Department is not writing deficiencies for the peer review process but is checking to verify whether or not a written plan exists at the facilities they visit. Violations of the Nurse Practice Act identified during a survey visit by the Health Department are referred to the BNE. Since the peer review process is mandated by the Nurse Practice Act, the Board may want to consider including language in the law to clarify this issue. (p. 2)

The third category, performance, related to the number of peer review committees functioning prior to as compared to after enactment of SB 1160 in health care facilities that regularly employ 10 or more registered nurses. A total of 356 respondents returned the Peer Review Questionnaire stating that they were employed by an organization employing ten or more RNs. Of these respondents, 44 (12.3%) (Group 2) indicated that they had no peer review process within their organization. The remainder of the group (312, 87.6%), forming Group 1, indicated that they had some type of a peer review process within their organization after SB 1160 went into effect.

The fourth category, adequacy of performance, related to the number of peer reviews completed by peer

review committees prior to as compared to after enactment of SB 1160. Adequacy of performance also referred to the quality and outcomes of peer reviews completed. Part 3 of the Peer Review Questionnaire relates to adequacy of performance of peer review committees.

During 1987, a total of 17 (5.5%) respondents reported a peer review conducted within their organization, while 289 (92.6%) reported that no peer reviews were performed. Within these 17 organizations a total of 171 peer reviews were performed during 1987. A larger number of respondents (88, 28.2%) reported a peer review taking place within their organization during 1988. This response resulted in 346 peer reviews being performed during 1988. By 1989, the majority of respondents (159, 51%) reported that at least one peer review had been conducted within their organization. A total of 661 peer reviews had been performed within these 159 organizations during 1989. Tables 24 and 25 provide descriptive data concerning the numbers of peer reviews performed prior to and after SB 1160.

Table 24

Frequencies & Percentage of Peer Reviews Completed Prior To and After SB 1160

Number Completed	Year 1987 n	1987 %	1988 n	1988 %	1989 n	1989 %
Zero	289	92.6	218	69.9	147	47.1
1	7	2.2	43	13.8	68	21.8
2	5	1.6	22	7.1	37	11.9
3-10	3	.9	20	6.6	48	15.4
> 10	2	.6	3	.9	6	1.8
No Response	6	1.9	6	1.9	6	1.9
Total	312	100.0	312	100.0	312	100.0

Table 25

Means and Standard Deviations of Numbers of Peer Reviews Completed Prior To and After SB 1160

Year	Mean	Standard Deviation
1987	.56	6.07
1988	1.19	6.24
1989	1.84	6.46

In relation to adequacy of performance, respondents were asked how many of the peer reviews completed resulted in a nurse being reported to the BNE (Table 26). Of the 171 peer reviews during 1987, fourteen (8.2%) resulted in a nurse being reported to the BNE. During 1988, 346 peer reviews were performed, resulting in 84 (24.3%) nurses being reported to the BNE. Almost

one-third (188, 28.4%) of the peer reviews conducted during 1989 (661) resulted in a nurse being reported. Respondents were also asked to identify how many of the peer reviews resulted in a nurse being reported to TPAPIN in lieu of the Board of Nurse Examiners (Table 27).

Table 26

Number of Peer Reviews Resulting in a Nurse Being Reported To the BNE

Year	Total Number of Peer Reviews	Number Reported To BNE	
	n	n	%
1987	171	14	8.2
1988	346	84	24.3
1989	661	188	28.4

Table 27

Number of Peer Reviews Resulting in a Nurse Being Reported To TPAPIN

Year	Total Number of Peer Reviews	Number Reported To TPAPIN	
	n	n	%
1987	171	4	2.3
1988	346	25	7.2
1989	661	55	8.3

The remainder of the questions in Part 3 were composed of a rating scale that ranged from "Strongly Disagree" (1) to "Strongly Agree" (5). Each statement could be responded to in relation to either prior to or after enactment of SB 1160 or both. Sub-group a (1a) (111, 35.6%) consisted of respondents who answered the entire questionnaire including "prior" and "after" responses of Part 3. Sub-group b (1b) (68, 21.8%) respondents completed only "after" responses on Parts 2 & 3. This process resulted in a total of 179 (57.4%) respondents completing some portion of Part 3 and 133 (42.6%) respondents not completing any portion of Part 3. Table 28 includes the mean ratings of peer review committees' adequacy of performance in relation to Part 3, items 23-30 of the questionnaire.

Table 28

Mean Ratings of the Adequacy of Performance of Peer Review Committees Prior To and After SB 1160

Descriptors	Prior n	Prior Mean	After n	After Mean
Feedback is provided by both verbal & written communication	99	3.36	179	4.27
Confidentiality is ensured	99	3.93	179	4.82
Provides evidence for new or altered policies & procedures	99	3.62	179	4.27
Results lead toward changes in educational offerings	102	3.39	176	3.78
Assist in identifying areas where practice patterns indicate more knowledge is needed	101	3.50	178	4.03
Assist in improving the quality of nursing practice *	100	3.64	179	4.02
Nurses are appraised of how their practice deviates from professional standards *	96	3.77	178	4.02
Repeated or multiple incidents by RNs are reported to the BNE *	96	3.21	169	4.06

*Indicates the item was reverse-scored during data analysis.

The fifth category, efficiency, pertained to the determination of costs related to functioning of peer review committees within health-care facilities employing 10 or more registered nurses, prior to as compared to

after enactment of SB 1160. Since this information was not directly included in the questionnaire, it was indirectly derived from responses to other items on the Peer Review Questionnaire. In table 29, the total number and mean number of hours organizations were involved in peer review activities per month prior to and after SB 1160 is presented.

Table 29

Efficiency of Peer Review Committees Prior To & After SB 1160 in Relation to Hours Expended

Year	Organizations n	Total Hours Per Month*	Mean Hours Per Month+
1987	33	531	16.09
1988	113	1499	13.26
1989	183	2323	12.69

*includes all hours reported by all organizations
+per organization

The mean cost per month and an annualized mean cost per organization are presented in Table 30. These figures were based upon an average hourly salary of $11.63 for an experienced staff RN in Texas during 1988 as reported by the Texas Hospital Association (1988). Staff RN salaries were selected since they were reported by the largest group of respondents (82.7%) as committee members.

Table 30

Efficiency of Peer Review Committees Prior To & After SB 1160 in Relation to Cost*

Year	Mean Hours Per Month	Mean Cost Per Month	Mean Cost Per Year
1987	16.09	$187.	$2,245.
1988	13.29	$154.	$1,854.
1989	12.69	$147.	$1,771.

*Per organization conducting peer reviews during year

Inferential statistics were also used to answer research question two, examining the differences in the use of peer review as a process of accountability prior to as compared to after SB 1160. The questionnaire was designed with three sections: Part 1 asked if a peer review process was present; Part 2 addressed the structure/policies of the peer review committee; and Part 3 was to be completed only if the committee had conducted a peer review. Both Parts 2 and 3 could be responded to in relation to prior and after SB 1160.

The questionnaire was completed by 312 nurses, who composed Group 1 described earlier. Group 1 respondents were further divided into sub-groups depending on the portions of the Peer Review Questionnaire completed. Sub-group a (1a) respondents (n=111; 36.6%) completed both the prior and after responses of Parts 2 and 3 of the questionnaire.

Sub-group b (1b) respondents (n=68; 21.8%) completed only the after responses of Parts 2 and 3. This response pattern suggests that prior to SB 1160, no peer review process existed within these institutions. Sub-group c (1c) consisted of those (n=69; 22.1%) who completed the prior and after responses of Part 2, indicating that a structure for peer review existed but that a peer review had not been performed. Sub-group d (1d) respondents (n=64; 20.5%) answered the after portion of Part 2 only. This response pattern indicates that no peer review process existed prior to SB 1160 and that following SB 1160, a structure for peer review existed, but no peer reviews were conducted.

The only subgroup which responded to the entire questionnaire, including the prior and after responses of Part 2 and 3, was 1a (n=111). A t-test for related samples was used to examine the difference between the means of the prior responses (before SB 1160) and the after responses (after SB 1160). The mean for the prior responses was 98.9, while the mean for the after responses was 123.6. The results for the t-test revealed $t(110) = -10.31$ with a significant difference between means at $p > .001$. This finding indicates that organizations, which had a structure for and had utilized peer review prior to SB 1160, significantly enhanced their accountability via the use of peer review following

SB 1160.

Group 1c (n=69) responded to the prior and after responses of Part 2 only. A t-test for related samples was used to examine the difference between the means of the prior responses and the after responses of 1c. The mean for the prior responses was 75.7, while the mean for the after responses was 85.7. The results of the t-test revealed $t(68) = -5.21$ with a significant difference between means at $p > .001$. This result indicates that the accountability process was significantly enhanced via the existence of a peer review structure within these organizations following SB 1160.

A t-test was used to examine the difference between means of 1a and 1b "after" scores. The mean of 1a was expected to be higher than the mean of 1b. 1a respondents indicated that their organization had performed at least one peer review prior to SB 1160, while 1b reported no peer reviews prior to SB 1160. There was no significant difference between means of the two groups. The mean for 1a (n=111) was 123.6, while the mean for 1b (n=68) was 124.3. The results of the t-test for independent groups revealed $t(171) = -.31$ with no significant difference between groups at $p = .756$. This finding indicates that there were no differences in the accountability process, related to the use of peer review following SB 1160, within organizations which had

an existing structure for peer review and had performed at least one peer review prior to SB 1160, and those which had a structure, but had never conducted a peer review prior to the bill.

Hospital size (number of beds) in which the respondents were employed was correlated with the after scores for groups 1a and 1b. The Spearman rho correlation coefficient yielded r= .1662 with p= .013. This finding signifies a low, but significant relationship existed between size of hospital and after scores of 1a and 1b. However, this relationship probably has no practical significance.

Two groups, 1c and 1d responded only to Part 1 and 2. This response pattern indicates that a structure for peer review existed within these organizations, but no peer reviews had been performed. Part 2 specifically addressed the structure/policy components of peer review. Group 1c responded to both the prior and after questions of Part 2. Group 1d responded only to the after questions of Part 2. A t-test was used to examine the difference between means of 1c and 1d "after" scores. There was no significant difference between means of the two groups. The mean for 1c (n=69) was 85.7, while the mean for 1d (n=64) was 89.4. The results of the t-test for independent groups revealed $t(131)$= -1.94 with no significant difference between groups at

$p = .054$. This indicates that there was no difference in the accountability process following SB 1160 between those organizations with a structure for peer review prior to the bill and those with no structure prior to the bill.

Summary of Findings

The sample consisted of 356 subjects. Three hundred twelve respondents (Group 1) indicated that a structure for peer review existed within their organizations or that a structure existed and had been utilized in conducting a peer review; and 44 respondents (Group 2) indicated that their organization employed 10 or more RNs, yet failed to have a peer review process. Group 1 consisted of 290 females and 19 males. Group 2 consisted of 43 females and one male. The majority of respondents in both groups were in the 31-50 year age range, and most were employed by acute care hospitals. In Group 1, the majority of the in-patient facilities were 50 beds or larger, yet smaller than 600 beds. The majority of Group 2 respondents were employed in in-patient facilities ranging in size from less than 50 beds to 199 beds.

More than a third of the respondents in Group 1 (131) and Group 2 (15) had more than twenty years nursing experience. Medical-surgical nursing was the major clinical practice area for over one-third of the

respondents in both groups. The majority of subjects in both groups were nurse administrators. Over one-third of the respondents in both groups had a bachelor's degree in nursing, and a large number of respondents in Group 1 (136) and Group 2 (17) held additional degrees other than nursing. The majority of subjects in Group 1 (161) were the chairperson of the peer review committee, while Group 2 respondents had no peer review committee.

Research Question One

Professional and organizational accountability related to professional nurse reporting were examined according to effort, performance, adequacy of performance, efficiency, and process.

1. Effort - As a result of SB 1160, the BNE was granted additional staff (total of 12) to handle complaints and conduct investigations into suspected violations of the nurse practice act. The number of field investigations increased considerably following SB 1160, from 6 in 1987 to 307 during 1989. The BNE also expended effort in educating nurses, employers, the public, and others of law and rule changes as a result of SB 1160. As mandated by SB 1160, the BNE increased its newsletter distribution from a total circulation of 1162 during 1987 to 144,532 during 1988 and 139,690 during 1989. The 1988 and 1989 newsletters provided information concerning the

changes in the Nurse Practice Act related to SB 1160 and provided summaries of final disciplinary action taken against violators of the practice act.

2. Performance - Complaints concerning professional nurses suspected of violating the practice act increased from 452 during 1987 to 832 during 1988 and 954 during 1989.

3. Adequacy of performance - SB 1160 resulted in an increase in the number of field investigations (described above); the number of disciplinary hearings; and the number of licenses monitored. The number of formal disciplinary hearings increased from 87 during 1987 to 117 during 1988. As a result of this increase, the BNE restructured its hearing process to provide two types of informal hearings, thereby decreasing the number of formal hearings to 76 during 1989. The average time for complaint resolution increased as a result of the complex nature of the practice related complaints.

During 1987, 134 disciplinary reports were filed with the NCSB. The number of reports increased to 141 during 1988 and to 165 during 1989. Most of these violations resulted in one of four types of action taken by the BNE: licensure revoked, suspension, probation, or reprimand. Case descriptors as reported to the NCSB indicated that

during 1988, 26% of the cases were drug related. By 1989, the percentage of cases related to drugs had decreased to 20%. Practice related violations increased in two categories: inconsistent nursing practice (1988=8%; 1989=24%); and administering medications (1988=30%; 1989=46%). The percent of violations related to misconduct decreased from 20% in 1988 to 6% in 1989; while violations resulting from either a conviction of a felony or action taken in another board's jurisdiction decreased from 24% in 1988 to 14% in 1989. The types of case descriptors indicates the seriousness of violations of the Nurse Practice Act.

4. Efficiency - Implementation and continuing operation of professional nurse reporting cost the State of Texas $246,300 during 1988 and $324,257 during 1989. The average cost of a formal disciplinary hearing during 1989 was $495 and the average cost of a field investigation was $122. This resulted in a total cost of $617 per violator during 1989. In 1987, the average cost of a formal disciplinary hearing and investigation was $565.
5. Process - In examining the attributes of professional nurse reporting, it was found that practice related complaints (unprofessional conduct) increased from 33% in 1987 to 57% during 1988 and 63%

during 1989. Peer review committees were the primary group reporting suspected violators to the BNE. However, it should be noted that the BNE includes in this particular category of complainants, reports from peer review committees, RNs, other health practitioners, and administrators. Numerous other categories of complainants were also utilizing professional nurse reporting.

The primary effect of SB 1160 was the large increase in number of reports of suspected violations of the Nurse Practice Act. Prior to SB 1160 most complaints were drug and alcohol related, after SB 1160 most complaints were practice related. The number of employers reporting has increased and possibly even resulted in inappropriate reporting. SB 1160 has resulted in a tremendous increase in workload for the BNE in all departments, often resulting in a strain on resources.

Research Question Two

Differences in the use of peer review as a process of accountability prior to and after SB 1160 were categorized according to Suchman's categories for evaluation:

1. Effort - Prior to SB 1160 the BNE expended no effort on peer review activities, except in preparing for the legislative session. Following SB 1160, a

substantial effort was expended by the BNE primarily in preparation and presentation of information regarding the implementation of peer review. Organizational effort increased from a mean of 1.7 hours per month involved in peer review activities in 1987 to 4.9 hours during 1988 and 7.78 hours during 1989.

2. Process - The mean ratings of the process dimensions of peer review indicated an increase in means following SB 1160 in all but one category. Process dimensions with the largest increase in means from prior to after were: committee members have an equal vote (prior=3.59; after=4.66); a written plan exists for identifying and reporting RNs (prior= 2.93; after=4.13); purposes, functions, policies and procedures of the committee are written (prior=3.08; after=4.44); and BNE Standards of Nursing Practice and Unprofessional Conduct are used as a guide (prior=3.58; after=4.57). Only one category showed no increase: the committee is democratically elected by the total RN group (prior=2.55; after=2.55). Descriptors with the least amount of increase were: the committee is not a disciplinary committee (prior=3.34; after=3.78); parliamentary procedure is followed during meetings (prior=3.44; after=3.89); and the committee is concerned with the

qualifications of RNs being reviewed (prior=3.75; after=4.07).

In examining the attribute of size of peer review committees, the mean number of nurse members was 6.19 (n=312) with a standard deviation of 2.91, and the mean number of non-nurse members was 0.56 (n=312) with a standard deviation of 6.07. Eighty-two percent (82%) of the committees had staff RN members, while 60% had nurse managers and 47.7% had nurse administrators. Peer review committees were more likely to deal with failure to conform to the minimum standards of acceptable professional nursing practice and failure to adequately care for a patient.

A small number of respondents expressed concern over unintentional effects of peer review as being increased anxiety and/or resentment (2). One respondent believed that peer review was being used for intimidation and harassment. The BNE identified unintentional effects as a lack of clarity within the statute regarding the committee's right to impose discipline and that peer review appears to be largely unregulated.

3. Performance - Of the 356 respondents employed by an organization which employs 10 or more RNs, 312 (87.6%) reported having some type of peer review process. Forty-four (44; 12.3%) respondents

indicated that no peer review process existed within their organization.

4. Adequacy of performance - During 1987, a total of 17 (5.5%) respondents reported a peer review conducted within their organization (n=312). A larger number of respondents (88, 28.2%) reported a peer review within their organization during 1988, and during 1989, a majority (159; 51%) reported a peer review. Of the peer reviews conducted during 1987, 14 nurses were reported to the BNE and 4 to TPAPIN. That number increased to 84 reported to the BNE during 1988 and 25 to TPAPIN. Peer reviews conducted during 1989 resulted in 188 nurses being reported to the BNE and 55 to TPAPIN.

   Mean ratings of the adequacy of performance of peer review committees showed an increase from prior to after SB 1160. Descriptors with the largest increases were: feedback is provided by both verbal and written communication (prior=3.36; after=4.27); confidentiality is ensured (prior=3.93; after=4.82); and repeated or multiple incidents by RNs are reported to the BNE (prior= 3.21; after=4.06). Descriptors with the least increase in means were: results lead toward changes in educational offerings (prior=3.39; after=3.78); peer review assists in improving the quality of nursing practice (prior=3.64;

after=4.02); and nurses are appraised of how significantly their practice deviates from professional standards (prior=3.77; after=4.02).

5. Efficiency - The mean cost per month per organizations conducting peer reviews were: during 1987 (n=33), $187; during 1988 (n=113), $154; and during 1989 (n=183), $147. Organizations conducting peer reviews spent $474 less during 1989 than they did during 1987.

Inferential statistics were also used to examine the differences in the use of peer review as a process of accountability prior to as compared to after SB 1160. The t-test for related samples revealed a significant difference between means of the prior responses and the after responses. A t-test for independent groups indicated that there was no significant difference between after score means of organizations who had a peer review process prior to SB 1160 and those who had no peer review process prior to SB 1160. The Spearman rho correlation revealed a minimal relationship between size of hospital and after scores on the peer review questionnaire.

CHAPTER 5

SUMMARY OF THE STUDY

The purpose of this study was to evaluate the effectiveness of SB 1160 in promoting accountability for professional nursing practice within the state of Texas. Research question one examined the differences in professional and organizational accountability as related to professional nurse reporting prior to and after enactment of SB 1160. Research question two examined the differences in peer review as a process of accountability before and after SB 1160.

Summary

A nonexperimental, explanatory evaluation research design was used to examine the effectiveness of SB 1160 in promoting nursing accountability within the state of Texas. Survey techniques were used to answer the research questions as related to Suchman's (1967) categories of evaluation. Quantitative and qualitative methods were used to analyze the survey data generated from these categories of evaluation. In answering research question one, data was obtained from abstract of BNE records, abstract of BNE Performance and Funds Management reports, results of the BNE implementation study, and semi-structured interviews with BNE staff.

The primary source of data for research question two was the Peer Review Questionnaire developed by the investigator. In addition, data was collected by abstract of BNE records and semi-structured interviews of BNE staff. The sample for research question two consisted of 356 peer review committee members. Of this group, 312 respondents indicated a peer review process existed within their organization and completed some portion of the questionnaire. Forty-four (44) respondents indicated that, even though their organization employed 10 or more RNs, no peer review process existed.

Descriptive data were summarized by measures of central tendency and variability. Data analysis included t-test for related and independent samples, and the Spearman rho correlation. In relation to research question two, a significant difference was found between before and after mean scores on the Peer Review Questionnaire for those respondents who answered the entire questionnaire (n=111) and those who responded to the prior and after responses of Part 2 only (n=69).

Discussion of Findings

In this section, the findings are discussed and related to the literature review and other research. However, this study is unique in examining the effectiveness of specific health care legislation, SB

1160. The findings relevant to mandatory reporting and peer review, as specified by SB 1160, are discussed in relation to Suchman's (1967) framework for evaluation. Suchman (1967) defined evaluation as the determination of the results attained by some activity designed to accomplish some valued goal or objective. The objective of SB 1160 was to enhance professional and organizational accountability related to professional nursing practice. Health care organizations and nurses involved in peer review and mandatory reporting activities following the enactment of SB 1160 were expected to display higher levels of professional accountability.

Effort

Effort is described as the quantity of activity and is measured as input regardless of output (Suchman, 1967). The activities of mandatory reporting and peer review consisted of the effort involved to enhance accountability. Mandatory reporting consists of effort to report incompetent professionals (Green, 1989). The results of this study indicated there was a substantial increase in effort expended by organizations and professionals in reporting of suspected violations of the nurse practice act. In addition, the BNE expended considerable effort in investigating and disciplining reported professional nurses following SB 1160.

The generally accepted definition of peer review is

an organized effort whereby practicing professionals review the quality and appropriateness of professional nursing practice (ANA, 1988). The results of this study indicated that as a result of SB 1160, an organized effort was made by health care organizations to establish written policies for peer review. The BNE also expended considerable effort to educate nurses concerning the implementation of peer review.

Performance

Performance relates to the results of the effort and is measured by output (Suchman, 1967). The performance of mandatory reporting is mandated by regulatory or legislative entities (Green, 1989), as it was in SB 1160. This process entails an ethical and legal responsibility to report incompetent practitioners (Cloutier, 1981; Green, 1989). SB 1160 has resulted in an increased output of reporting of suspected violations to the nurse practice act. Although the number of professional nurse complaints more than doubled following SB 1160, the actual number of complaints remains small in porportion to the total RN population.

In relation to peer review performance, substantial output was generated by health care organizations following SB 1160. Only a small percentage (12.3%) of health care organizations surveyed failed to establish peer review committees as mandated by SB 1160.

Adequacy of Performance

Adequacy of performance relates to adequacy in terms of objective or purpose and is measured in terms of effectiveness (Suchman, 1967). The primary purpose of mandatory reporting and peer review is to establish professional accountability for the delivery of quality nursing care (ANA, 1973; Zimmer, 1974; Steel, Donabedian, 1980; Lang & Clinton, 1983; and ANA, 1988).

The objective of mandatory reporting is to report incompetence or violations of the professional practice act (Green, 1989). This study indicates that mandatory reporting has resulted in a significant increase in the number of practice related complaints received by the BNE, and the number of hearings resulting in disciplinary action against incompetent practitioners. This finding is consistent with that of other states which have reported increased reporting following the enactment of mandatory reporting requirements (Luckenbill-Britt & Stuhler-Schlag, 1987).

This study indicated that the actual number of health care organizations conducting peer reviews increased following implementation of SB 1160. However, during 1989 only 51% of the organizations surveyed reported conducting a peer review. This finding suggests that many health care organizations are utilizing the peer review process primarily as a reactive process by

reviewing only reportable incidences. This decision is in accordance with the BNE guidelines for implementing the peer review process (1989). However, peer review is intended to be a proactive process which establishes professional accountability for the delivery of quality nursing care thereby promoting and improving nursing care (ANA, 1973; Zimmer, 1974; Steel, 1985; & ANA, 1988).

In this study, t-tests were utilized to examine the overall effectiveness of SB 1160 in promoting accountability via peer review. A significant difference was found between before and after scores, suggesting that SB 1160 had significantly improved accountability via the peer review process. In contrast, respondents in the BNE study perceived peer review as being only slightly to moderately effective (Houfek et al., 1990).

The purposes of peer review, as identified by the ANA (1973, 1988) include: to evaluate the quality and quantity of nursing care; to identify the extent of consistency to established standards; identify strengths and weaknesses of nursing care; to provide evidence to improve nursing care; and to identify areas of practice in which more knowledge is needed. All mean scores for descriptors specific to the purposes of peer review were higher following SB 1160 than prior to the bill. However, descriptors with the smallest increase in mean after scores relating to adequacy of performance suggests that

peer review does not adequately assist in improving the quality of nursing practice and that nurses are not adequately appraised of how their practice deviates from professional standards. Houfek et al. (1990) reported a similar finding in that peer review was not perceived as greatly helping facilities identify potential sources of unsafe care.

Numerous authors suggested that a primary purpose of peer review is to identify behaviors not in compliance with standards and correcting those deficiencies via education (ANA, 1973; Mullins et al., 1979; O'Loughlin & Kaulbach, 1981; Anderson & Davis, 1987; Davis, 1987; Wollard & Peterson, 1989). Findings of this study indicated that descriptors directly related to this purpose had the smallest increase in after mean scores, indicating an inadequate performance. The BNE study also found that the presence of peer review did not increase educational opportunities within organizations (Houfek et al., 1990).

Maintaining confidentiality of peer review proceedings is a primary indication of adequacy of performance (Ross, 1987; ANA, 1988). Houfek et al. (1990) found that RNs were concerned about the confidentiality of peer review proceedings following the implementation of SB 1160. However, this study's findings indicated that peer review committees are

ensuring confidentiality of peer review proceedings.

Efficiency

Efficiency is the ratio between effort and performance and is measured by costs vs benefit (Suchman, 1967). The appropriation (cost) of SB 1160 was minimal in relation to the benefits of increased reporting of incompetent practitioners. The actual cost of complaint investigations by the BNE rose only slightly, however, the quality of investigations were enhanced via an increase in the number of field investigations.

According to the BNE implementation study (Houfek et al., 1990), chairpersons identified peer review as a time-consuming and costly process. However, this study indicated that the cost of conducting peer reviews actually decreased following SB 1160. The mean hours per month spent in peer review activities also decreased following the implementation of SB 1160, although the total hours per month spent in peer review activities by all organizations increased.

Process

Process is described as the explanations of how and why a program functions (Suchman, 1967). Willmann & Jordan (1987) described three categories of reporting requirements established by SB 1160. Mandatory reporting of unsafe care by RNs and health care

organizations; permissive reporting of health care facilities and other health care providers; and optional reporting to the peer assistance program. The process components of mandatory reporting and optional reporting to TPAPIN indicate improvements following the enactment of SB 1160. This study did not examine permissive reporting.

Peer review is described as a process by which practicing nurses make judgments about the quality of nursing care provided by peers (ANA, 1975). Professional standards of practice are used as a measure for this process (Ramphal, 1974; Zimmer, 1974; O'Loughlin & Kaulbach, 1981; and ANA, 1988). Process descriptors with the highest after mean scores were those relating to the existence of a written plan, including policies and procedures, for peer review within organizations following SB 1160. This finding is consistent with BNE study findings which indicated that following SB 1160 RNs were more attentive to policies and procedures related to peer review (Houfek et al., 1990).

All mean after scores for process descriptors were increased from prior scores except one. Nurses perceived no improvement in the peer review committee being democratically elected by the total RN group. The ANA (1988) recommended that peer review committees use a democratic process to elect members. Houfek et al. (1990) found that RNs perceived that they had

insufficient input in the selection of committee members and that the majority of committees consisted of appointed members.

Due process, including participation in committee hearings and written rebuttal, is a primary component of peer review (Klein, 1986; Ross, 1987; & ANA, 1988). According to Anderson & Davis (1987), the peer review process should also result in direct feedback to the professional being reviewed. This study indicated that due process was enhanced following SB 1160. Similar results were reported by Houfek et al. (1990).

Houfek et al. (1990) examined the attributes of peer review committee size and composition. The BNE study indicated that the mean number of peer review committee members was 7.36, with 6.79 nurse members and 0.62 non-nurse members. This study revealed a mean of 6.75 members (6.19 nurse members & 0.56 non-nurse members) with a composition similar to that found in the BNE study.

Unintentional effects of peer review found in this study included resentment concerning the process, anxiety created by the process, and the use of intimidation and harassment during the process. O'Loughlin & Kaulbach (1981) reported similar effects after instituting peer review on a neurosurgical unit. The authors reported that RNs perceived peer review as threatening, not only for the nurse being reviewed, but also by the peer

performing the review. Similar findings were reported by Houfek et al. (1990), in that some RNs inappropriately used the peer review process by dealing with personal conflicts and that RNs experienced anxiety in relation to peer review.

Conclusions and Implications

Based on the findings of this study, the following conclusions were made:

1. Professional and organizational accountability relating to professional nurse reporting have been enhanced by the enactment of SB 1160. All categories of Suchman's evaluation framework indicated an enhanced effort, performance, adequacy of performance, efficiency and process. However, proportionally speaking in relation to the total RN population, a small number of RNs are being reported to the BNE for suspected violations of the professional practice act. This result suggests that under reporting is probably occurring.
2. The use of peer review as a process of accountability has been enhanced by the enactment of SB 1160. Again, all categories of Suchman's evaluation framework indicated an improvement following enactment of SB 1160. However, peer review is primarily being utilized as a reactive process and not in a proactive manner aimed at improving the overall quality of

nursing care delivery within health care organizations in Texas.

The implications of the results of this research are numerous. Peer review and mandatory reporting are concepts which are being advocated as a means to ensure professional accountability for the delivery of quality nursing care (Greenlaw, 1980; Steel, 1985; ANA, 1988; & Green, 1989). The findings of this study support the utilization of these quality assurance mechanisms as a means of promoting professional and organizational accountability. The findings of this study have implications for those groups primarily responsible for the delivery of quality nursing care within the state of Texas: nurses, health care organizations, the BNE, and the Texas legislature.

This study indicated that health care organizations supporting an environment conducive to the application of peer review and mandatory reporting are more likely to display higher levels of professional and organizational accountability. Of primary importance to nursing and health care organizations is the finding that mandatory reporting and peer review do promote accountability and therefore enhance quality of care. The development of long range plans which ensure adequate resources for promotion of these quality assurance mechanisms will facilitate consumer protection and

promote quality of care.

The findings of this study indicated that peer review was used as a reactive mechanism, therefore, not supporting the theoretical literature advocating a proactive utilization of the peer review process. In light of an increased demand for quality health care by consumers and a litigation prone society, society and health care would be better served by a proactive utilization of the peer review process. The development of peer review models which are proactive, thereby promoting the delivery of quality nursing care, are essential to professional and organizational accountability. Quality of care is incumbent upon the outcomes of the peer review process focusing upon identification of practice areas needing improvement.

The role of the BNE in advising and educating RNs and health care organizations concerning mandatory reporting and peer review is critical to the delivery of quality health care to Texas citizens. This study indicated that there will probably be a continued increase in number of practice related complaints. This finding has implications for the BNE to continue indepth field investigations which will promote consumer protection as well as provider protection. The increase in practice related complaints implies that the BNE continue to develop mechanisms which facilitate and

enhance the diciplinary process. Additional guidelines which clarify and facilitate compliance with the requirements of SB 1160 would promote accountability. The BNE may want to consider emphasizing the proactive use of peer review to promote quality nursing care.

This study implies that the Texas Legislature has a moral obligation to continue funding the BNE at a level which promotes consumer protection via the use of peer review and mandatory reporting. Amendments to SB 1160 and the nurse practice act which would strengthen compliance with and enforcement of these quality assurance mechanisms would promote consumer protection.

Recommendations for Further Study

If nursing is to reach an effective level of professional accountability, research must be pursued in regard to the effectiveness of these quality assurance mechanisms. This evaluation research study can be utilized as a basis for more specific studies on the relationships between mandatory reporting, peer review and professional accountability. Some suggestions for future studies extending from this research are as follows. Studies should be designed which:

1. Identify and describe the concepts of mandatory reporting and/or peer review and develop models based upon these concepts.
2. Explore the relationships and/or differences between

mandatory reporting and peer review and professional accountability.

3. Test hypothesized relationships between mandatory reporting, peer review, and professional accountability.
4. Test the application of peer review models in practice.
5. Evaluate the long term effects of SB 1160 in promoting professional and organizational accountability.
6. Further establish the reliability and validity of the Peer Review Questionnaire.

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APPENDIX A

Senate Bill 1160 Sections & Goals

The contents of the bill fall into three main sections or under three main goals. A summary of these three sections (TNA, 1987) with goals identified by the investigator include:

1. Section 1 - amended the article in the Nurse Practice Act that covers disciplinary proceedings.

   Goal 1 - to strengthen and facilitate the Board of Nurse Examiners' disciplinary role in monitoring quality care for consumers.

2. Section 2 - requires mandatory reporting of care by registered nurses which is below the current standard. Designates who must report, protection for those reporting, and how the reports should be handled by the Board of Nurse Examiners.

   Goal 2 - to enhance professional and organizational accountability via mandatory reporting of professional nurses practicing below the current standards of practice.

3. Section 3 - established the statutory framework for peer review committees for professional nurses. Also provides for immunity for civil liability for persons participating in peer review and confidentiality of the peer review process.

   Goal 3 - to establish peer review as a process of accountability in assuring the quality of professional nursing practice.

APPENDIX B

Senate Bill 1160

S.B. No. 1160

AN ACT

relating to the regulation of professional nursing, the establishment of professional nursing peer review, and certain professional nursing reporting procedures; providing a penalty.

Be it enacted by the Legislature of the State of Texas:

SECTION 1. Article 4525, Revised Statutes, is amended to read as follows:

Art. 4525. DISCIPLINARY PROCEEDINGS. (a) The board of nurse examiners may refuse to admit persons to its examinations, may refuse to issue a license or certificate of registration or to issue a certificate of re-registration, may refuse to issue a temporary permit, may issue a warning or reprimand *with or without stipulations*, may suspend for any period not to exceed 2 years, or may revoke the license or certificate of any practitioner of professional nursing, for any of the following reasons:

(1) The violation of any of the provisions of this law, any rule, regulation not inconsistent with this law, or order issued hereinunder.

(2) Is guilty of fraud or deceit in procuring or attempting to procure a license to practice professional nursing.

(3) Conviction of a crime of the grade of felony, or a crime of lesser grade which involves moral turpitude, *or any conduct resulting in the revocation of probation imposed pursuant to such conviction.*

(4) The use of any nursing license, certificate, diploma or permit, or transcript of such license, certificate, diploma or permit, which has been fraudulently purchased, issued, counterfeited, or materially altered.

(5) The impersonation of, or the acting as a proxy for, another in any examination required by law to obtain a license to practice professional nursing.

(6) Aiding or abetting, directly or indirectly, or in any manner whatsoever, any unlicensed person in connection with the unauthorized practice of professional nursing.

(7) Revocation, suspension, or denial of *or any other action relating to* the license to practice nursing in another jurisdiction. Certified copy of the order of denial, suspension, [or] revocation, *or any other action* shall be conclusive evidence thereof.

(8) Intemperate use of alcohol or drugs if the nurse knows or should know that the effects of that use endangers or could endanger patients. Intemperate use includes but is not limited to practicing professional nursing or being on duty or call while under the influence of alcohol or drugs.

(9) Unprofessional or dishonorable conduct which, in the opinion of the board, is likely to deceive, defraud, or injure patients or the public.

(10) Adjudication of mental incompetency.

(11) Lack of fitness to practice by reason of mental or physical health that could result in injury to patients or the public.

(12) Failing to care adequately for patients or to conform to the minimum standards of acceptable professional nursing practice that, in the opinion of the board, exposes a patient or other person unnecessarily to risk of harm.

(b) Proceedings under this *article* [~~Article~~] shall be begun by filing *a written complaint* [~~charges~~] with the board of nurse examiners [~~in writing and under oath~~]. Such *complaint* [~~charges~~] may be made by any person or *filed by the board on its own initiative. Unless it would jeopardize an investigation, the board shall notify the registered nurse that a complaint has been filed and the nature of the complaint* [~~persons~~]. An information file about each complaint filed relating to a licensee shall be maintained by the board. If a written complaint is filed with the board relating to a licensee, the board at least as frequently as quarterly and until final disposition of the complaint, shall notify the *party that filed the complaint* [~~parties to the complaint~~] of the status of the *file* [~~complaint~~] unless [~~the~~] notice would jeopardize an [~~undercover~~] investigation. The board shall make *a timely and appropriate* [~~such~~] preliminary investigation of the *complaint* [~~charges as it deems necessary~~] and may issue a warning or reprimand to the person *against whom the complaint was filed* [~~charged~~]. *If the investigation reveals probable cause to take further disciplinary action, the board shall file formal charges against the registered nurse stating the provisions of this chapter or the board's rules that are alleged to have been violated and a brief description of the acts or omissions that constituted the violation.* If the board proposes to refuse to admit a person to its examination, to refuse to issue a temporary permit, license, certificate of registration, certificate of re-registration, or to suspend or revoke a person's permit, license, or certificate, the person is entitled to a hearing before the board. *The hearing may be before a subcommittee of the board, a majority of which is composed of registered nurses. The person shall on request be granted a hearing before the entire board.* Proceedings for *a* [~~these~~] disciplinary *action* [~~actions~~] are governed by the Administrative Procedure and Texas Register Act[~~, as amended~~] (Article 6252-13a, Vernon's Texas Civil Statutes). *The board may assess a person found to have violated any provision of this chapter the administrative costs of conducting a hearing to determine that violation.* If a licensed professional nurse voluntarily surrenders *his or her* [~~said~~] license to the board and executes a sworn statement that he or she no longer desires to be licensed, the board may revoke *his or her* [~~said~~] license without the necessity of formal charges, notice, or opportunity of hearing.

(c) Any person whose license or certificate to practice professional nursing has been revoked or suspended by the board or who has been otherwise disciplined by the board may take an appeal to any of the district courts in the county of residence, but the decision of the board shall not be enjoined or stayed except on application to such district courts after notice to the board. Upon application the board may reissue a license or certificate to practice professional nursing to a person whose license has been revoked or suspended but such application, in case of revocation, shall not be made prior to one year after the revocation was issued and shall be made in such manner and form as the board may require.

(d) The board shall have the right and may, upon majority vote, rule that the order denying an application for a license or suspending any license be probated so long as the probated practitioner conforms to such orders and rules as the board may set out in the terms of probation, *including, but not limited to, limiting the practice of the person to, or by excluding, one or more specified activities of professional nursing or requiring the person to submit to supervision, care, counselling, or treatment of a practitioner designated by the board.* The board, at the time of probation, shall set out the period of time which shall constitute the probationary period; provided further that the board may at any time while the probationer remains on probation hold a hearing and upon majority vote rescind the probation and enforce the board's original action in denying or suspending such license. The said hearing to rescind the probation shall be called by the president of the board who shall cause to be issued a notice setting the time and place for the hearing and containing the charges or complaints against the probationer, said notice to be served on the probationer or his or her counsel at least 20 days prior to the time set for the hearing. Notice shall be sufficient if sent by registered or certified mail to the person charged at the *person's most recent address as shown in the records of the*

board [~~address shown on his or her most recent application for certificate of registration or reregistration~~].

(e) The board of nurse examiners is charged with the duty of aiding in the enforcement of the provisions of this chapter, and may retain legal counsel to represent the board, but prior to retaining outside legal counsel, the board shall request the attorney general to perform such services and may only retain outside counsel if the attorney general so certifies to the board that the attorney general cannot provide such services. The board shall have the power to issue subpoenas, compel the attendance of witnesses, administer oaths to persons giving testimony at hearings, and cause the prosecution of all persons violating any provisions of this chapter. It shall keep a record of all its proceedings and make an annual report to the Governor. Any member of the board may present to a prosecuting officer complaints relating to violations of any of the provisions of this chapter, and the board through its members, officers, counsel, or agents shall assist in the trial of any cases involving alleged violation of this chapter, subject to the control of the prosecuting officers. The Attorney General is directed to render such legal assistance as may be necessary in enforcing and making effective the provisions of this chapter; provided that this shall not relieve the local prosecuting officers of any of their duties under the law as such.

(f) Any person, corporation, or other entity, however organized, shall respond promptly and fully to any request for information by the board and to any subpoena issued by the board. No such request or subpoena may be refused, denied, or resisted except on the grounds that such request or subpoena calls for information within the attorney/client privilege. No other privilege shall apply to proceedings of the board. All subpoenas issued at the request of the board may be served either personally by a board investigator, by certified mail, or in any other manner authorized by law. The board may pay a reasonable fee for photocopies subpoenaed at the board's request not to exceed the amount the board charges for copies of its records. The board shall protect, to the extent possible, the identity of patients named in information received by the board.

(g) A complaint and investigation concerning a registered nurse under this article and all information and materials compiled by the board in connection with a complaint and investigation are confidential and not subject to disclosure under Chapter 424, Acts of the 63rd Legislature, Regular Session, 1973 (Article 6252-17a, Vernon's Texas Civil Statutes), and not subject to disclosure, discovery, subpoena, or other means of legal compulsion for their release to anyone other than the board or its employees or agents involved in licensee discipline except that this information may be disclosed to:

(1) persons involved with the board in a disciplinary action against the nurse;

(2) professional nursing licensing or disciplinary boards in other jurisdictions;

(3) peer assistance programs approved by the board under Chapter 701, Acts of the 69th Legislature, Regular Session, 1985 (Article 5561c-3, Vernon's Texas Civil Statutes);

(4) law enforcement agencies; and

(5) persons engaged in bona fide research, if all individual-identifying information has been deleted.

(h) The filing of formal charges against a registered nurse by the board, the nature of those charges, disciplinary proceedings of the board, and final disciplinary actions, including warnings and reprimands, by the board are not confidential and are subject to disclosure in accordance with Chapter 424, Acts of the 63rd Legislature, Regular Session, 1973 (Article 6252-17a, Vernon's Texas Civil Statutes).

(i) If the board takes a final disciplinary action, including a warning or reprimand, against a registered nurse under this article, the board shall immediately send a copy of the board's final order to the nurse and to the last known employer of the nurse.

SECTION 2. Title 71, Revised Statutes, is amended by adding Article 4525a to read as follows:

Art. 4525a. PROFESSIONAL NURSE REPORTING

Sec. 1. Each registered nurse having reasonable cause to suspect that a registered nurse has exposed or is likely to expose a patient or other person unnecessarily to a risk of harm because of unprofessional conduct, failure to care adequately for a patient, failure to conform to the minimum standards of acceptable professional nursing practice, or impaired status shall report in a signed, written report to the board the name of the nurse committing the violation or suspected violation and any other pertinent information within the nurse's knowledge as the board may require. A registered nurse without personal knowledge of the nurse's actions is not required to report under this section if she or he has reasonable cause to believe the nurse has already been reported.

Sec. 2. (a) Each hospital, health science center, nursing home, home health agency, other health-care facility, state agency, political subdivision, school of professional nursing, temporary nursing service, or person that employs, hires, or contracts for the services of registered nurses that terminates, suspends, or takes other substantive disciplinary action as defined by the board against a registered nurse because a patient or other person was exposed or is likely to be exposed unnecessarily to a risk of harm because of unprofessional conduct, failure to care adequately for a patient, failure to conform to the minimum standards of acceptable professional nursing practice, or impaired status shall report in writing to the board the name of the nurse and such other pertinent information within the knowledge of the facility, agency, school, or person.

(b) Each hospital, nursing home, health science center, home health agency, other health-care facility, state agency, political subdivision, school of professional nursing, temporary nursing service, or person that regularly employs, hires, or otherwise contracts for the services of 10 or more registered nurses shall develop a written plan for identifying and reporting registered nurses in its service who expose or are likely to expose patients or other persons unnecessarily to a risk of harm because of unprofessional conduct, failure to care adequately for a patient, failure to conform to the minimum standards of acceptable professional nursing practice, or impaired status. The plan must include an appropriate process for the review of any incident reportable under this section by a professional nursing peer review committee established and operated under Article 4525b, Revised Statutes, and for the affected nurse to submit rebuttal information to that committee.

(c) The requirement that a report to the board be reviewed by a professional nursing peer review committee applies only to a required report, and review by the peer review committee is only advisory. The requirement may not be construed as subjecting an employer's or other person's administrative decision to discipline a registered nurse to the peer review process or as preventing an employer or other person from taking disciplinary action before review by the peer review committee is conducted. The review by the peer review committee established under Subsection (b) of this section must include a determination as to whether or not the nurse undergoing review engaged in conduct that exposed or was likely to expose a patient or other person unnecessarily to risk of harm because of unprofessional conduct, failure to care adequately for a patient, failure to conform to the minimum standards of acceptable professional nursing practice, or impaired status. The peer review committee's determination shall be included in the report made to the board under Subsection (a) of this section.

Sec. 3. Each professional association of registered nurses or any organization that conducts a certification or accreditation program for registered nurses that expels, decertifies, or takes any other substantive disciplinary action, as defined by the board, against a registered nurse as a result of the registered nurse's failure to conform to the minimum standards of acceptable professional nursing practice shall report in writing to the board the nurse's name and such other pertinent information within the organization's knowledge as the board may require.

Sec. 4. Each state agency that surveys hospitals, nursing homes, health science centers, home health agencies, or other health-care facilities or agencies with respect

to quality of professional nursing care provided, unless otherwise expressly prohibited by state or federal law shall report in writing to the board any registered nurse that it has reason to believe exposed or is likely to expose patients or other persons unnecessarily to a risk of harm because of unprofessional conduct, failure to care adequately for a patient, failure to conform to the minimum standards of acceptable professional nursing practice, or impaired status.

Sec. 5. (a) Every insurer providing professional liability insurance to a professional nurse covering claims arising from providing or failing to provide professional nursing care shall submit to the board the report or data required by this section at the time prescribed.

(b) The report or data shall be provided with respect to a complaint filed against an insured in court, if the complaint seeks damages relating to the insured's conduct in providing or failing to provide professional nursing care, and with respect to settlement of a claim or lawsuit made on behalf of the insured.

(c) If a registered nurse named as a defendant in a claim arising from providing or failing to provide professional nursing care does not carry or is not covered by professional liability insurance or is insured by a nonadmitted carrier, the information required to be reported under this section shall be the responsibility of the registered nurse.

(d) The following report or data shall be furnished by an insurer or nurse under this section to the board within 30 days after date of receipt by the insurer of a complaint:

(1) the name of the person against whom the claim is filed;

(2) the policy number;

(3) the policy limits;

(4) a copy of the petition;

(5) a copy of the answer; and

(6) other pertinent data and information within the knowledge of the person required to make the report, as the board may require.

(e) The following report or data and information shall be furnished by an insurer or nurse under this section to the board within 30 days after the date of a judgment, dismissal, or settlement of suit involving the insured or nurse or settlement of any claim on behalf of the insured or nurse without the filing of a lawsuit:

(1) the date of the judgment, dismissal, or settlement;

(2) whether an appeal has been taken and by which party;

(3) the amount of the settlement or judgment against the insured or nurse; and

(4) other pertinent information within the knowledge of the person required to make the report, as the board may require.

Sec. 6. Not later than the 30th day after the date on which a person known to be a registered nurse, licensed or otherwise lawfully practicing in this state or applying to be so licensed to practice, is convicted of a felony, a misdemeanor involving moral turpitude, a violation of state or federal narcotics or controlled substance laws, or an offense involving fraud or abuse under the Medicare or Medicaid programs or after a determination by a court that adjudges or includes a finding that a registered nurse is mentally ill or mentally incompetent, whether or not the conviction, adjudication, or finding is entered, withheld, or appealed under the laws of this state, the attorney representing the state shall cause the clerk of the court of record in which the conviction, adjudication, or finding was entered to prepare and forward to the board a certified true and correct abstract of the record of the court governing the case. The abstract must include the name and address of the nurse or applicant, the nature of the offense committed, the sentence, and the judgment of the court. The board shall prepare the form of the abstract and shall distribute copies of it to all district attorney and county attorney offices within this state with appropriate instructions for preparation and filing.

Sec. 7. A registered nurse may file a signed, written report to the appropriate licensing board to report a licensed health care practitioner, agency, or facility that the nurse has reasonable cause to believe has exposed a patient to substantial risk of harm as a result of failing to provide patient care that conforms to the minimum standards of acceptable and prevailing professional practice.

Sec. 8. If a nurse required to be reported under this article is impaired or suspected of being impaired by dependency on chemicals or by mental illness, that nurse, in lieu of being reported to the board, may be reported to a peer assistance program approved by the board under Chapter 701, Acts of the 69th Legislature, Regular Session, 1985 (Article 5561c-3, Vernon's Texas Civil Statutes).

Sec. 9. An individual, organization, agency, facility, or other person is not liable in any civil action for failure to file a report required by this article, but the appropriate state licensing agency may take action against a licensed practitioner, agency, or facility for not reporting as required.

Sec. 10. (a) An individual, organization, agency, facility, or other person that, without malice, makes a report required or permitted or reasonably believed to be required or permitted under this article or chapter is immune from civil liability and may not be subjected to any other retaliatory action as a result of making that report.

(b) An individual, organization, agency, facility, or other person named as a defendant in any civil action or subjected to any other retaliatory action as a result of filing a report required, permitted, or reasonably believed to be required or permitted under this article or chapter may file a counterclaim in any pending action or may prove a cause of action in a subsequent suit to recover defense costs, including reasonable attorney's fees and actual and punitive damages if the suit or retaliatory action is determined to be frivolous, unreasonable, or taken in bad faith.

Sec. 11. (a) No person shall suspend, terminate, or otherwise discipline or discriminate against a person reporting, without malice, under this article. A person has a cause of action against an individual, organization, agency, facility, or other person that suspends or terminates the employment of the person or otherwise disciplines or discriminates against the person for reporting under this article. The person may recover:

(1) actual damages, including damages for mental anguish even though no other injury is shown, or $1,000, whichever amount is greater;

(2) exemplary damages;

(3) costs of court; and

(4) reasonable attorney's fees.

(b) In addition to amounts recovered under Subsection (a) of this section, a person whose employment is suspended or terminated in violation of this section is entitled to:

(1) reinstatement in the employee's former position or severance pay in an amount equal to three months of the employee's most current salary; and

(2) compensation for wages lost during the period of suspension or termination.

(c) A person who sues under this section has the burden of proof, but in the event of a determination by either the board or a court of competent jurisdiction that the report or abstract made the subject of the cause of action was authorized or required under Section 1, 2, 3, 4, 5, 6, 7, or 8 of this article and that it was made without malice, it is a rebuttable presumption that a person's employment was suspended or terminated for reporting under this article if the person is suspended or terminated within 60 days after making the report.

(d) An action under this article may be brought in the district court of the county:

(1) in which the plaintiff resides;

(2) in which the plaintiff was employed by the defendant; or

(3) in which the defendant conducts business.

Sec. 12. (a) The board shall notify each registered nurse who is reported to the board under Section 1, 2, 3, 4, or 5 of this article of the filing of the report unless doing so would jeopardize an active investigation.

(b) The registered nurse or the nurse's authorized representative is entitled on request to review any report submitted to the board under Section 1, 2, 3, 4, or 5 of this article unless doing so would jeopardize an active investigation. The identity of the individual making or signing the report may not be revealed.

(c) The registered nurse or authorized representative may place into the record a statement of reasonable length containing the registered nurse's rebuttal of any information existing in the report. That statement shall at all times accompany that part of the report being rebutted. The board, in investigating the report, shall review that statement and evaluate any reasons asserted by the nurse as justifying his or her conduct.

Sec. 13. If at any time the board determines that a report submitted under this article is without merit, the report shall be expunged from the registered nurse's file.

Sec. 14. A report required or authorized under this article and the identity of the person making the report are confidential and may not be disclosed except as follows:

(1) the board may use the information in connection with an investigation or disciplinary action against a licensee or in the subsequent trial or appeal of a board action or order;

(2) the board may disclose the information to a licensing or disciplinary authority of another jurisdiction;

(3) the board may disclose the information to a peer assistance program approved by the board under Chapter 701, Acts of the 69th Legislature, Regular Session, 1985 (Article 5561c-3, Vernon's Texas Civil Statutes);

(4) the board may disclose the information to a person engaged in bona fide research or other educational purpose if all individual-identifying information is first deleted;

(5) with respect to any report made under Section 2 of this article, the board, on the request of any organization or other person required to report under Section 2 of this article, shall provide to the organization or person information about the allegations contained in the report, the findings of the peer review committee, and the status of the board's investigation; or

(6) the information may be disclosed in any civil suit in which a person is named as a defendant as a result of the person making the report or in the prosecution of any cause of action based on a claim that the person making the report was subject to retaliatory action as a result of making the report.

Sec. 15. (a) This article does not prevent disclosure under Article 4525, Revised Statutes, of formal charges filed by the board or a final disciplinary action taken by the board as a result, in whole or in part, of the submitting of a report under this article. In no event may any report or information submitted as required or authorized by this article be available for discovery or court subpoena or introduced into evidence in a professional nursing liability suit arising out of the provision or failure to provide professional nursing services.

(b) The filing of a report under this article with the board pursuant to this article, an investigation by the board, or any disposition by the board does not prevent an individual, agency, facility, or other person from taking disciplinary action against a registered nurse.

(c) The reporting required under this article does not constitute state action on behalf of the person or organization reporting.

(d) The duty to report or any other provisions under this article may not be nullified through contract.

Sec. 16. (a) The board shall disseminate at least twice a year and at other times determined necessary by the board information that is of significant interest to

professional nurses and employers of professional nurses in Texas. The information shall include summaries of final disciplinary action taken against registered nurses by the board since its last dissemination of information.

(b) The board shall inform, in the manner it determines appropriate, registered nurses, facilities, agencies, and other persons of their duty to report under this article.

SECTION 3. Title 71, Revised Statutes, is amended by adding Article 4525b to read as follows:

Art. 4525b. PEER REVIEW

Sec. 1. In this article:

(1) "Professional nursing peer review committee" means a committee composed of at least a majority of registered nurses established under the authority of the governing body of a national, state, or local professional nursing association, a school of professional nursing, the nursing staff of a hospital, health science center, nursing home, home health agency, temporary nursing service, or other health-care facility, or state agency or political subdivision for the purpose of conducting peer review. A professional nursing peer review committee includes the employees and agents of the committee, including assistants, investigators, intervenors, attorneys, and any other person or organization that is employed by or serves the committee in any capacity.

(2) "Peer review" means the evaluation of professional nursing services, the qualifications of professional nurses, the quality of patient care rendered by professional nurses, the merits of complaints concerning professional nurses and professional nursing care, and determinations or recommendations regarding complaints, including:

(A) the accuracy of nursing assessments and observations;

(B) appropriateness and quality of the care rendered by a professional nurse;

(C) reports made to a professional nursing peer review committee concerning activities under the committee's review authority;

(D) reports by a professional nursing peer review committee to other committees or to the board as permitted or required by law; and

(E) implementation of the duties of a professional nursing peer review committee by its members, agents, or employees.

Sec. 2. (a) Except as otherwise provided by this article, all proceedings of a professional nursing peer review committee are confidential and all communications made to a professional nursing peer review committee are privileged. A member, agent, or employee of a professional nursing peer review committee or a participant in any proceeding before the committee may not disclose or be required to disclose a communication made to the committee or a record or proceeding of the committee.

(b) A person who attends a proceeding of a professional nursing peer review committee may not disclose or be required to disclose any information acquired in connection with or in the course of the proceeding or disclose any opinion, recommendation, or evaluation of the committee or any member of the committee.

(c) The members of a professional nursing peer review committee and the persons who provide information to the committee may not be questioned about their testimony before the committee or about opinions formed as a result of the committee proceedings.

(d) Except as otherwise permitted by this article, all information made confidential by this section is not subject to subpoena or discovery in any civil matter, is not admissible as evidence in any judicial or administrative proceeding, and may not be introduced into evidence in a professional nursing liability suit arising out of the provision of or a failure to provide professional nursing services.

Sec. 3. (a) A professional nursing peer review committee shall disclose on request written or oral communications made to the committee and the records and proceedings of the committee to:

(1) the state board of registration or licensure of any state; or

(2) a law enforcement authority investigating a criminal matter.

(b) A professional nursing peer review committee may disclose written or oral communications made to the committee and the records and proceedings of the committee to:

(1) the association, school, agency, facility, or other organization under whose authority the committee is established;

(2) another professional nursing peer review committee;

(3) a peer assistance program approved by the board under Chapter 701, Acts of the 69th Legislature, Regular Session, 1985 (Article 5561c-3, Vernon's Texas Civil Statutes);

(4) appropriate state or federal agencies or accrediting organizations which accredit health-care facilities or schools of nursing or which survey facilities for quality of care; or

(5) persons engaged in bona fide research, if all individual-identifying information is deleted.

(c) If a professional nursing peer review committee discloses information under Subsection (a) of this section that could result in the reprimand, suspension, termination, or other disciplinary action of a professional nurse, or itself recommends or takes such action, the committee shall provide the nurse with a detailed summary of information disclosed or the basis of its action or recommendation. The nurse shall be permitted an opportunity to offer rebuttal information and to submit a rebuttal statement of reasonable length. The rebuttal statement shall be included with the information disclosed.

(d) If a committee discloses information to a nurse under this section, the committee has not by that action waived the privilege of nondisclosure of committee information and proceedings.

(e) The peer review committee disclosing the information and the person receiving information disclosed under this section shall protect, to the extent possible, the identity of patients.

Sec. 4. (a) A member of a professional nursing peer review committee or a person participating in peer review under this article who is named as a defendant in a civil action or subjected to other retaliatory action as a consequence of the person's participation in peer review may use information that is confidential under this article in defense of the civil action or in a civil action based on an allegation of retaliation for the person's participation in peer review.

(b) If a person discloses information under this section, the person has not by that action waived the privilege of nondisclosure of all other information privileged under this article.

Sec. 5. A cause of action does not accrue against the members, agents, or employees of a professional nursing peer review committee or against a school of professional nursing, hospital, nursing home, home health agency, health science center, other health-care facility, the nursing staff of such a facility, professional nursing association, or other organization from any act, statement, determination or recommendation made, or act reported, without malice, in the course of peer review as defined in this article. A person who, without malice, furnishes records, information, or assistance to a professional nursing peer review committee is not liable in a civil action based on the person's participation or assistance in peer review and may not be subjected to retaliatory action as a result of such act.

Sec. 6. A professional nursing peer review committee, a person participating in peer review, or an organization, named as a defendant in any civil action or subjected to other retaliatory action as a result of participation in peer review, may file a counterclaim in any pending action or may prove a cause of action in a subsequent suit to recover any defense costs, including court costs, reasonable attorney's fees, and

actual and punitive damages if the suit or retaliatory action is determined to be frivolous, unreasonable, without foundation, or taken in bad faith.

Sec. 7. (a) A court may not enjoin the activities of a professional nursing peer review committee under this article.

(b) The provisions of this article may not be nullified by contract.

SECTION 4. Article 4527, Revised Statutes, is amended to read as follows:

Art. 4527. FEES. The Board of Nurse Examiners shall establish reasonable and necessary fees for the administration of its functions in amounts not to exceed:

Admission fee to examination	*$200*	[~~75~~]
Duplicate or substitute of current certificate	*25*	[~~10~~]
Duplicate or substitute of permanent certificate	*25*	[~~10~~]
Duplicate permits	*15*	[~~5~~]
Endorsement with or without examination	*150*	[~~75~~]
Re-registration	*50*	[~~25~~]
Issuance of a temporary permit under Article 4523	*25*	[~~15~~]
Reactivating from inactive status	30	
Accreditation of new schools and programs	150	
[~~Approval of exchange visitor programs~~	~~75~~]	
[~~Proctoring of examinations of examinees from other states~~	~~115~~]	
Filing of affidavits in re-change of name	10	
Verification of records	*50*	[~~10~~]
Bad checks	*25*	[~~15~~]
Advanced Nurse Practitioner-initial credentials	*50*	
Advanced Nurse Practitioner-renewal of credentials	*25*	

The Board shall not maintain unnecessary fund balances, and fee amounts shall be set in accordance with this requirement. The Board shall set and collect a sales charge for copies of any paper or record in the office of the Board and for any printed material published by the Board. The charges are to be in an amount considered sufficient to reimburse the Board for its actual expenses. All fees received by said Board under this law shall be placed in the State Treasury to the credit of a special fund to be known as the "Professional Nurse Registration Fund" and the Comptroller shall upon requisition of the Board from time to time draw warrants upon the State Treasurer for the amounts specified in such requisition; provided, however, all fees collected by the Board and deposited in the Professional Nurse Registration Fund shall be expended as specified by itemized appropriation in the General Appropriations Act and shall be used by the Board and under its directions, only for purposes of carrying out this Act. *The Board may use any of the fees and charges collected by it, as necessary, to retain, hire, or contract for additional prosecutors, hearing examiners, investigators, and support staff as necessary to aid in the investigation of complaints and the prosecution of persons subject to the Board's jurisdiction.* This provision shall apply to all fees [~~on hand on September 1, 1981, and all fees~~] of whatsoever nature as permitted by law [~~now or as amended~~]. The state auditor shall audit the financial transactions of the Board during each fiscal biennium.

SECTION 5. Article 4527b, Revised Statutes, is amended to read as follows:

Art. 4527b. PENALTY. A person who violates any provision of *Article 4527a, Revised Statutes, commits an offense. Except as provided by this section, an offense under that article is a Class A misdemeanor. If it is shown in the trial of a person allegedly in violation of that article that the person has once before been convicted of a violation of Article 4527a, on conviction the person shall be punished for a third degree felony. Each day of violation constitutes a separate offense. On final conviction of an offense under that article, a person forfeits all rights and privileges conferred by virtue of licensure under* this chapter [~~is guilty of a misdemeanor and upon conviction is punishable by a fine of not less than $50 nor more than $500, confinement in jail for a term not to exceed 30 days, or both~~].

SECTION 6. Each entity in existence on the effective date of this Act that is required by Subsection (b), Section 2, Article 4525a, Revised Statutes, as added by this Act, to develop a plan for reporting certain actions of registered nurses shall have the plan in operation on January 1, 1988.

SECTION 7. This Act takes effect September 1, 1987.

SECTION 8. The importance of this legislation and the crowded condition of the calendars in both houses create an emergency and an imperative public necessity that the constitutional rule requiring bills to be read on three several days in each house be suspended, and this rule is hereby suspended.

Passed the Senate on April 13, 1987, by a viva-voce vote; and that the Senate concurred in House amendments on May 22, 1987, by a viva-voce vote. Passed the House, with amendments, on May 21, 1987, by a non-record vote.

Approved June 18, 1987.

Effective Sept. 1, 1987.

APPENDIX C

Suchman's Categories of Evaluation in Relation To SB 1160, Specific to Sections 2 & 3

I. Section 2. Article 4525a. Professional Nurse Reporting

A. Goal: to enhance professional and organizational accountability via mandatory reporting of professional nurses practicing below the current standards of practice.

B. Research question: How do professional and organizational accountability relating to professional nurse reporting differ prior to as compared to after enactment of 1987 Texas SB 1160?

C. Categories of Evaluation

1). Effort - BNE staff hours in handling professional nurse reporting prior to as compared to after enactment of SB 1160.

Data collected by - abstract of BNE records and semi-structured interviews of BNE staff.

2). Performance - Yield of suspected cases of nurses practicing below the current standards of practice prior to as compared to after enactment of SB 1160, reported by:
   a. registered nurses
   b. organizations
   c. professional associations
   d. state agencies that survey health care facilities
   e. insurers of professional liability insurance
   f. attorneys representing the state

Data collected by - abstract of BNE complaint log of suspected incompetent practitioners.

3). Adequacy of Performance - Yield of formal charges filed by the BNE or final disciplinary action taken by the BNE prior to as compared to after enactment of SB 1160, as related to professional nurse reporting by:
   a. registered nurses

b. organizations
c. professional associations
d. state agencies that survey health care facilities
e. providers of professional liability insurance
f. attorneys representing the state.

Data collected by - abstract of BNE records.

4). Efficiency - estimates of costs expended by the BNE in relation to adequacy of performance of professional nurse reporting prior to as compared to after enactment of SB 1160.

Data collected by - abstract of BNE Performance And Funds Management Reports.

5). Process - according to three dimensions:
a. the attributes of mandatory reporting
b. the population exposed to mandatory reporting
c. types of effects produced by mandatory reporting (cognitive, attitudinal, behavioral); unintentional effects

Data collected by - abstract of BNE records; results from BNE implementation study; and semi-structured interviews of BNE staff.

II. Section 3. Article 4525b. Peer Review

A. Goal: To establish peer review as a process of accountability in assuring the quality of professional nursing practice.

B. Research question: What are the differences in the use of peer review before as compared to after the enactment of 1987 Texas SB 1160?

C. Categories of Evaluation
1). Effort - BNE staff hours & organizational staff hours involved in peer review prior to as compared to after enactment of SB 1160.

Data collected by - abstract of BNE records and semi-structured interview of BNE staff; peer review questionnaire developed by investigator.

2). Performance - The number of peer review committees functioning prior to as compared

to after enactment of SB 1160, in health-care facilities that regularly employ 10 or more registered nurses.

Data collected by - peer review questionnaire developed by the investigator.

3). Adequacy of Performance - The number of peer reviews completed by peer review committees prior to as compared to after enactment of SB 1160, in regard to:
   a. the evaluation of professional nursing services
   b. the qualifications of professional nurses
   c. the quality of patient care rendered by professional nurses
   d. the merits of complaints concerning professional nurses and professional nursing care
   e. determinations or recommendations regarding complaints, including: the accuracy of nursing assessments and observations; and appropriateness and quality of the care rendered by a professional nurse.
   f. professional nurse reporting

   Data collected by - peer review questionnaire developed by the investigator.

4). Efficiency - determination of costs related to functioning of peer review committees within health-care facilities employing 10 or more registered nurses, prior to as compared to after enactment of SB 1160.

   Data collected by - peer review questionnaire developed by the investigator.

5). Process - according to four dimensions:
   a. attributes of peer review committees
   b. the population exposed to peer review
   c. situational context in which peer review occurs
   d. the types of effects produced by peer review, including unintentional effects.

   Data collected by - peer review questionnaire developed by the investigator.

APPENDIX D

Agency Permission

TEXAS WOMAN'S UNIVERSITY
COLLEGE OF NURSING
DENTON, TEXAS 76204

DALLAS CENTER
1810 INWOOD ROAD
DALLAS, TEXAS 75235

HOUSTON CENTER
1130 M. D. ANDERSON BLVD.
HOUSTON, TEXAS 77030

AGENCY PERMISSION FOR CONDUCTING STUDY*

THE BOARD OF NURSE EXAMINERS FOR THE STATE OF TEXAS

GRANTS TO ALEXIA E. GREEN

a student enrolled in a program of nursing leading to a Doctoral Degree at Texas Woman's University, the privilege of its facilities in order to study the following problem:

"An Evaluation of the 1987 Texas Senate Bill 1160: The Effectiveness of Legislated Accountability Requirements For Nurses"

The conditions mutually agreed upon are as follows:

1. The agency (may) (~~may not~~) be identified in the final report.
2. The names of consultative or administrative personnel in the agency (may) (~~may not~~) be identified in the final report.
3. The agency (wants) (~~does not want~~) a conference with the student when the report is completed.
4. The agency is (willing) (~~unwilling~~) to allow the completed report to be circulated through interlibrary loan.
5. Other _____

Date: 7-23-90

Louise Waddill
Signature of Agency Personnel

Alexia Green
Signature of Student

Terry A. Throckmorton
Signature of Faculty Advisor

* Fill out and sign three copies to be distributed as follows: Original-Student; First copy - agency; Second copy - TWU College of Nursing.

/bc

APPENDIX E

Coding Forms

CODING FORM A

Directions for Use:
For use in performing record abstracts from data contained in the BNE Complaint Log. Please fill in blanks and check categories which apply. Additional notes or comments may be included.

1. Log Number: _____

2. Date of Complaint: _____

3. Suspected Violation of Nurse Practice Act:

Article Number/s:	Rule Number/s:
_____	_____
_____	_____
_____	_____
_____	_____

4. Type of Complainant Filing Report: _____

_____

5. Comments:

CODING FORM B

Directions for Use:
For use in performing record abstracts from Disciplinary Report Form filed by BNE with the National Council of State Boards of Nursing. Please check appropriate spaces and fill in the blanks. Additional comments may be included.

1. Code Number: _____

2. Gender: _____

3. Disciplinary Action/s - Check all that apply:

   _____ Licensure Denied

   _____ Licensure Limited

   _____ Licensure Revoked

   _____ Voluntary Surrender

   _____ Summary Suspension

   _____ Suspension

   _____ Probation

   _____ Fine

   _____ Reprimand

   _____ Other (Describe): _____

4. Case Description - Check all that apply:

   A. Drugs

      _____ Abuse

      _____ Diversion

      _____ Self Administration

      _____ Use on Duty

      _____ Writing Illegal Prescription

      _____ Other (Describe): _____

B. Inconsistent Nursing Practice

_____ Leaving Duty Station

_____ Failure to Maintain Minimum Standards

_____ Incompetent Practice

_____ Other (Describe): _____

C. Administering Medications

_____ Charting Errors

_____ Failure to Follow Medical Orders

_____ Failure to Have Wastage Witnessed

_____ Failure to Document Administration

_____ Other (Describe): _____

D. Misconduct Relating to the Practice of Nursing

_____ Practice Beyond the Scope of License

_____ Fraudulent Practice

_____ Other (Describe): _____

E. Conviction of

_____ Felony

_____ Misdemeanor

_____ Action Taken In Another Jurisdiction

5. Comments:

CODING FORM C

Directions for Use:
For use in performing record abstracts from BNE Performance & Funds Management Reports submitted to the Executive & Legislative Budget Offices.

1. Report Date: _____

2. Section I - Comments from Administrator's General Statement relating to Mandatory Reporting and Peer Review:

3. Section II Part A Program Performance Report:

   a. Number of currently licensed RNs

      Actual Performance _____

      Annual Percent Variation _____

   b. Number of Complaints Received:

      Actual Performance _____

      Annual Percent Variation _____

   c. Number of Complaints Resolved:

      Actual Performance _____

      Annual Percent Variation _____

   d. Average Time for Complaint Resolution:

      Actual Performance _____

      Annual Percent Variation _____

   e. Number of Investigations Completed:

      Actual Performance _____

      Annual Percent Variation _____

   f. Number of Field Investigations:

      Actual Performance _____

      Annual Percent Variation _____

   g. Average Field Investigation Cost:

Actual Performance _____

Annual Percent Variation _____

h. Number of Informal Disciplinary Hearings:

Actual Performance _____

Annual Percent Variation _____

i. Number of Informal Disciplinary Hearings:

Actual Performance _____

Annual Percent Variation _____

j. Number of Formal Disciplinary Hearings:

Actual Performance _____

Annual Percent Variation _____

k. Average Cost of Formal Disciplinary Hearing:

Actual Performance _____

Annual Percent Variation _____

l. Number of Hearings Resulting in Disciplinary Action:

Actual Performance _____

Annual Percent Variation _____

m. Average Time For Disciplinary Action:

Actual Performance _____

Annual Percent Variation _____

n. Number of Licenses Monitored Per Board Order:

Actual Performance _____

Annual Percent Variation _____

o. Number of Reinstatement Hearings:

Actual Performance _____

Annual Percent Variation _____

4. Explanations Regarding Section II, Part A:

APPENDIX F

Interview Guide

1. What differences have you seen in professional nurse reporting since the enactment of SB 1160 (September 1, 1987)?

   a. What differences have you seen in relation to reporting by other professional nurses?

   b. What differences have you seen in relation to reporting by organizations?

2. Approximately how many BNE staff hours were involved in professional nurse reporting prior to as compared to after enactment of SB 1160?

   a. Has your staff increased?

   b. Are there plans for increasing staffing in the future?

3. How has organizational operation of the BNE been affected by the enactment of SB 1160?

4. Is funding for the professional nurse reporting program adequate?

5. What differences have you seen in the use of peer review as a process of accountability prior to as compared to after enactment of SB 1160?

6. Approximately how many BNE staff hours are involved in regulation of the peer review process prior to as compared to after the enactment of SB 1160?

7. What unintentional or unexpected effects have you seen as a result of the enactment of SB 1160?

8. What suggestions for changes would you recommend in relation to SB 1160?

APPENDIX G

Demographic Data Form

Instructions: Please place a check by the correct answer.

1. Gender:
   _____ (1) Male
   _____ (2) Female

2. Age:
   _____ (1) Less than 20
   _____ (2) 20-30
   _____ (3) 31-40
   _____ (4) 41-50
   _____ (5) 51-60
   _____ (6) Greater than 60

3. Place of employment in nursing:
   _____ (1) Acute Care Hospital
   _____ (2) Nursing Home/Extended Care Facility
   _____ (3) School of Nursing
   _____ (4) Freestanding Clinic
   _____ (5) Community/Public Health Agency
   _____ (6) Home Health Agency
   _____ (7) Nursing Agency
   _____ (8) Other, Please specify:_____

4. If place of employment is an in-patient facility, please indicate the number of beds:
   _____ (1) Less than 50 beds
   _____ (2) 50-99 beds
   _____ (3) 100-199 beds
   _____ (4) 200-399 beds
   _____ (5) 400-599 beds
   _____ (6) 600 or more beds

5. Number of years of nursing experience:
   _____ (1) Less than 1 year
   _____ (2) 1-5 years
   _____ (3) 6-10 years
   _____ (4) 11-15 years
   _____ (5) 16-20 years
   _____ (6) more than 20 years

6. Major clinical practice area:
   _____ (1) Community/Public Health Nursing
   _____ (2) Maternal/Child Health Nursing
   _____ (3) Medical/Surgical Nursing
   _____ (4) Psychiatric/Mental Health Nursing
   _____ (5) Other. Please specify:_____

7. Position in nursing:
   _____ (1) Staff Nurse
   _____ (2) Nursing Manager
   _____ (3) Nursing Administrator
   _____ (4) Nurse Educator
   _____ (5) Clincial Nurse Specialist
   _____ (6) Nurse Practioner
   _____ (7) Other. Please specify:_____

8. Highest education in nursing:
   _____ (1) Diploma
   _____ (2) Associate Degree
   _____ (3) Bachelor's Degree
   _____ (4) Master's Degree
   _____ (5) Doctoral Degree

9. Highest education not in nursing:
   _____ (1) Associate Degree
   _____ (2) Bachelor's Degree
   _____ (3) Master's Degree
   _____ (4) Doctoral Degree

10. Position on peer review committee:
   _____ (1) Chairperson
   _____ (2) Member
   _____ (3) Other. Please specify:_____

11. Composition of committee members: (Check all that apply)
   _____ (1) Nurse Administrators
   _____ (2) Nurse Managers
   _____ (3) Staff RNs
   _____ (4) RN Faculty Members
   _____ (5) Staff LVNs
   _____ (6) Other. Please specify:_____

12. Number of members on peer review committee. Please specify:_____
   _____ (1) Nurses
   _____ (2) Non-nurses

13. How many peer reviews did the peer review committee perform? Please specify number:
   _____ (1) During 1987
   _____ (2) During 1988
   _____ (3) During 1989

14. How many of the peer reviews completed resulted in a nurse being reported to the Board of Nurse Examiners? Please specify number:
   _____ (1) During 1987
   _____ (2) During 1988
   _____ (3) During 1989

15. How many of the peer reviews completed resulted in a nurse being reported to TPAPIN in lieu of the Board of Nurse Examiners? Please specify number:
   _____ (1) During 1987
   _____ (2) During 1988
   _____ (3) During 1989

16. Please estimate how many total hours (including all members) per month the peer review committee is involved in peer review activities:
   _____ (1) During 1987
   _____ (2) During 1988
   _____ (3) During 1989

17. Approximately how many RNs are employed by your institution/agency, including full & part time?
   _____ (1) Less than 10
   _____ (2) 10-49
   _____ (3) 50-99
   _____ (4) 100 or more

APPENDIX H

Peer Review Questionnaire

PEER REVIEW QUESTIONNAIRE

Instructions:
There are three possible options for completing this questionnaire. Please complete only those parts which apply to your institution.

Part 1:
If your institution does not currently have a peer review process please indicate below and proceed to the demographic data questions.

_____ No peer review process.

Part 2:
If your institution has a peer review process, please complete part 2 which addresses the structure/ policies of your peer review committee. Also complete the demographic data questions. Proceed to Part 3 if indicated.

Each of the following is a statement concerning the peer review process. Each statement will require two responses from you:

1.) the first response will address the peer review process in your institution prior to enactment of SB 1160 (before Jan. 1, 1988) and;
2.) your second response will address the period after enactment of SB 1160 (beginning Jan. 1, 1988). Please circle the number that best describes your reaction to that particular statement.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

1. Every member of the peer review committee has an equal vote.

Prior:	1	2	3	4	5
After:	1	2	3	4	5

2. Standards of practice are used to evaluate nursing care.

Prior:	1	2	3	4	5
After:	1	2	3	4	5

3. Registered nurse(s) are not reviewed by individuals of the same rank or standing.

Prior:	1	2	3	4	5
After:	1	2	3	4	5

4. Peer review activities are focused on the practice decisions of professional nurses to determine the appropriateness and timeliness of those decisions.

Prior:	1	2	3	4	5
After:	1	2	3	4	5

5. A written plan does not exist for identifying and reporting registered nurses who expose or are likely to expose patients to risk or harm.

Prior:	1	2	3	4	5
After:	1	2	3	4	5

6. The peer review committee is not composed of a majority of RNs.

Prior:	1	2	3	4	5
After:	1	2	3	4	5

7. Purposes, functions, policies and procedures of the committee are not written.

Prior:	1	2	3	4	5
After:	1	2	3	4	5

8. Peer review is used to promote and improve nursing care.

Prior:	1	2	3	4	5
After:	1	2	3	4	5

9. A request for peer review may be initiated by any healthcare provider or patient.

Prior:	1	2	3	4	5
After:	1	2	3	4	5

10. A registered nurse would not always be reported to the Board of Nurse Examiners for conscious disregard of patient safety.

Prior:	1	2	3	4	5
After:	1	2	3	4	5

11. The peer review committee offers commendation and/or constructive criticism of nursing care performance.

Prior:	1	2	3	4	5
After:	1	2	3	4	5

12. The institution/agency assumes cost of staff participationin the peer review process.

Prior:	1	2	3	4	5
After:	1	2	3	4	5

13. The peer review committee is not democratically elected by the total RN group.

Prior:	1	2	3	4	5
After:	1	2	3	4	5

14. The peer review committee is a disciplinary committee.

Prior:	1	2	3	4	5
After:	1	2	3	4	5

15. The peer review committee members do not represent various nursing specialties and positions.

Prior:	1	2	3	4	5
After:	1	2	3	4	5

16. Parliamentary procedure is not followed during peer review committee meetings.

Prior:	1	2	3	4	5
After:	1	2	3	4	5

17. The responsibility of the peer review committee is to determine if patients receive adequate nursing care and whether nursing standards have been met.

Prior:	1	2	3	4	5
After:	1	2	3	4	5

18. The peer review committee uses the Board of Nurse Examiners' Standards of Nursing Practice(Rule 217.11) and Unprofessional Conduct (Rule 217.3) as a guide for evaluation.

Prior:	1	2	3	4	5
After:	1	2	3	4	5

19. Registered nurses being reviewed are not permitted to submit a written rebuttal to the peer review committee.

Prior:	1	2	3	4	5
After:	1	2	3	4	5

20. Any registered nurse(s) being reviewed by the peer review committee would be reported to the Board of Nurse Examiners.

Prior:	1	2	3	4	5
After:	1	2	3	4	5

21. The peer review committee is not concerned with the qualifications of registered nurses being reviewed.

Prior:	1	2	3	4	5
After:	1	2	3	4	5

22. Registered nurse(s) being reviewed are not given opportunities for meeting with the peer review committee.

Prior:	1	2	3	4	5
After:	1	2	3	4	5

****

Part 3:

Please complete part three only if your committee has conducted a peer review either prior to or after enactment of SB 1160.

23. Feedback to registered nurse(s) under review is provided by both verbal and written communication.

Prior:	1	2	3	4	5
After:	1	2	3	4	5

24. The utmost care is taken to ensure confidentiality of the peer review proceedings.

Prior:	1	2	3	4	5
After:	1	2	3	4	5

25. The peer review process provides evidence for use as the basis of recommendations for new or altered policies and procedures to improve nursing care.

1	2	3	4	5
1	2	3	4	5

26. Results of the peer review process leads toward changes in educational offerings needed to ensure quality.

Prior:	1	2	3	4	5
After:	1	2	3	4	5

27. The peer review process assists in identifying areas where practice patterns indicate more knowledge is needed.

Prior:	1	2	3	4	5
After:	1	2	3	4	5

28. The peer review process does not assist nurses in improving the quality of their practice.

Prior:	1	2	3	4	5
After:	1	2	3	4	5

29. Registered nurses being reviewed are not appraised of how significantly their practice deviates from accepted professional standards.

Prior:	1	2	3	4	5
After:	1	2	3	4	5

30. Repeated or multiple incidents by a registered nurse are not always reported to the Board of Nurse Examiners for further evaluation.

Prior:	1	2	3	4	5
After:	1	2	3	4	5

31. How many peer reviews did the peer review committee perform? Please specify number:
_____ During 1987
_____ During 1988
_____ During 1989

32. How many of the peer reviews completed resulted in a nurse being reported to the Board of Nurse Examiners? Please specify number:
_____ During 1987
_____ During 1988
_____ During 1989

33. How many of the peer reviews completed resulted in a nurse being reported to TPAPPIN in lieu of the Board of Nurse Examiners?
_____ During 1987
_____ During 1988
_____ During 1989

34. Types of behaviors your committee may deal with are listed below. Please rank order them from most often encountered (1) to least often encountered (4).
_____ Unprofessional conduct.
_____ Failure to care adequately for a patient.
_____ Failure to conform to the minimum standards of acceptable professional nursing practice.
_____ Impaired status.

COMMENTS:

APPENDIX I

Board of Nurse Examiners' Guidelines For Implementation of Peer Review

GUIDELINES FOR IMPLEMENTING THE PEER REVIEW PROCESS

Peer review is defined in Article 4525b, Section 1(2), Revised Civil Statutes of Texas. The responsibility of the peer review committee is to determine if the patient received adequate nursing care and whether nursing standards have been met, not to discipline the nurse. Discipline of the employee is the responsibility of the employer. The recommendations of the committee are advisory. The committee may also positively reinforce the nurse whose care exceeds the standards of the facility.

The legislature, through the Nurse Practice Act, has mandated the establishment of peer review committees in any setting where 10 or more registered nurses (either full-time or part-time) are employed.

The following guidelines are offered to assist in implementing the peer review process.

I. A written plan shall be developed for identifying and reporting registered nurses in its service who expose or are likely to expose patients or other persons unnecessarily to a risk of harm because of:

A. Unprofessional conduct;

B. Failure to care adequately for a patient;

C. Failure to conform to the minimum standards of acceptable professional nursing practice; or

D. Impaired status

II. The plan should address:

A. The review of any reportable incident; and

B. The mechanism by which the written rebuttal from the nurse under review is received and considered by the committee; e.g.:

1. Personal appearance before the committee, and/or
2. Notice by certified mail.

NOTE: The written rebuttal becomes a part of the peer review committee's report.

III. The peer review committee as defined in the Practice Act (Article 4525b), shall be composed of a majority of RNs. Institutional policy determines who serves on the committee. The following are suggestions for developing the committee:

A. Members should represent various nursing specialties and positions.

B. Staggered terms for committee members is recommended.

C. Purposes, functions, policies and procedures of the committee should be written. The following points are offered for consideration:

1. Peer review is defined as the evaluation of professional nursing services, the qualifications of professional nurses, the quality of patient care rendered by professional nurses, the merits of complaints concerning professional nurses and professional nursing care, and determinations or recommendations regarding complaints.

a) The law mandates that the committee will review reportable incidents as defined in Article 4525a, Section 2(b). (Reactive)

b) An optional purpose of peer review may be to promote and improve nursing care and/or to modify conditions that impede the performance of nursing care. (Proactive)

2. The peer review process may be initiated upon receipt of:

a) any allegations about unsafe nursing practice or suspected violation of the nurse practice act; and/or

b) unsafe conditions which endanger patients.

3. The request for review may be initiated by RN, LVN, MD, other healthcare providers, patients or the Peer Review Committee.

4. The request may be initiated by a written statement describing the facts.

5. Confidentiality must be maintained under the law. Consult legal counsel for advice regarding the:

a) storage of records;

b) use of numbers as opposed to names; and

c) confidentiality of proceedings of the committee and communications to the committee.

6. The committee's decision should be reported by written communication within 5 working days to nursing administration.

D. Parliamentary procedure should be followed.

E. Information which might be included in the Peer Review Committee minutes includes:

1. meeting agenda
2. date and time of meeting
3. committee members present
4. purpose of meeting
5. allegations presented against the RN
6. documentation of the evidence presented before the committee - verbal and written
7. findings of committee
8. committee recommendations
9. rebuttal statement of the RN

IV. The plan should address collection of evidence to be considered by the committee and may include:

A. Verbal testimony

B. Written statements

C. Incident reports

D. Patient care records

E. Personnel/departmental records

V. When the committee hears all relevant evidence and makes a decision, the peer review process is complete and the committee findings and recommendations are final.

VI. Related findings which have an impact on safe patient care and warrant attention should be reported to the nursing administration. If investigation of additional nursing personnel is indicated by the evidence and the peer review plan allows for the committee to initiate investigations, the committee should proceed with its own investigation and peer review.

VII. If the incident is reported to the Board of Nurse Examiners then the findings of the Peer Review Committee, including the nurse's written rebuttal, shall be submitted to the Board along with the signed complaint.

VIII. Principles to guide the peer review committee's determination for reporting findings to the Board of Nurse Examiner's are:

A. Conscious disregard to patient's safety.

B. Patterns/accumulations of incidents.

IX. A guide for the committee is the Board's Standards of Nursing Practice (Rule 217.11) and Unprofessional Conduct (Rule 217.13).

X. The peer review committee should be readily identifiable within the facility's committee structure.

This information is provided for your consideration and use in developing and implementing a peer review plan. The information is not a mandate, rule or regulation. It is provided in response to the numerous questions which have arisen regarding the implementation of the Peer Review process.

Attached is a checklist which may be helpful in the analysis and evaluation of the written plan for peer review committees.

Should you have further questions, please contact the Board of Nurse Examiners, P.O. Box 140466, Austin, Texas, 78714. (512) 835-4880.

APPENDIX J

Blueprint of the Peer Review Questionnaire and Demographic Data Form

Suchman's Categories of of Evaluation	Question * Number
1. Effort - Organizational staff hours involved in peer review before & after SB 1160	D 12 & 16
2. Performance - the number of peer review committees functioning before & after SB 1160	D 2 Part I
3. Adequacy of Performance - the number of peer reviews completed by peer review committees before & after SB 1160, in regard to:	
a. the evaluation of professional nursing services	D 13 & 17 Q 4, 7, 11, 17, Q18, 25, 31, 34
b. the qualifications of professional nurses	Q 3, 18, 21, 26 Q 27
c. the quality of patient care rendered by professional nurses	Q 2, 4, 8, 11 Q 18, 26, 28, 34
d. the merits of complaints concerning professional nurses & professional nursing care	Q 9, 17, 18, 19
e. determinations or recommendations regarding complaints	Q 10, 18, 19, Q 23, 34
f. professional nurse reporting	D 14 & 15 Q 10, 20, 30, Q 32, 33
4. Efficiency - determination of costs related to functions of peer review committees before & after SB 1160	D 16 Q 12

Blueprint Continued:

5. Process - according to 4 dimensions:

a. attributes of peer review committees	D 1-12 Q 1, 5, 6, 15
b. the population exposed to peer review	D 1-11 Q 15, 34
c. situational context in which peer review occurs	Q 1, 13, 15, 16, Q 19, 22, 23, Q 24, 29
d. the types of effects produced by peer review	Q 23, 29, 34

*Codes:
D = Demographic Data Form
Q = Questionnaire, Part II & III
Part I = Questionnaire, Part I

APPENDIX K

Cover Letters

May 4, 1990

Dear Nursing Colleague:

As a member of the nursing peer review committee, you have a very important role. Your experience in this role has provided you with valuable insights into the effectiveness of peer review committees. I need your assistance in evaluating Texas Senate Bill 1160, the Nursing Quality Assurance Bill. One component of this bill mandated the establishment of peer review committees in all institutions employing 10 or more registered nurses.

Have you wondered about the effect of this mandate? Please help me examine this very important topic by participating in this study. Your participation in this study could assist in upgrading the quality of nursing practice within the State of Texas. Your participation would be greatly appreciated.

Your completion of both components of this survey will require approximately 15-30 minutes. Please do not place your name on the survey. Each questionnaire has an identification number which will allow me to check them off the mailing list when they are returned. Your participation in this study is, of course, totally voluntary. Returning the completed questionnaire is considered as your consent to participate. If you decide not to participate please put an "X" in the box at the bottom of this page.
After completing the questionnaire and demographic data forms, please return them in the enclosed postage paid envelope. If you have any questions or concerns regarding this study or topic, please contact me at 409-880-8836, Monday - Friday during business hours. I am a doctoral student in nursing at Texas Woman's University, Houston, Texas and I amnot employed by the Board of Nurse Examiners.

Thank you for your interest in this research and your thoughtful participation.

Sincerely,

Alexia Green RN, MSN
Lamar University
P.O. Box 10208
Beaumont, Tx 77710

☐

June 1, 1990

Dear Nursing Colleague:

During May you were mailed a questionnaire concerning the peer review process. This is the second mailing of that questionnaire, in hopes that you will complete and return it within five days of receipt. Your participation in this study is, of course, totally voluntary. If you decide not to participate please put an "X" in the box at the bottom of this page and return in the enclosed envelope. If you could share your reasons for not participating it would help in planning future research.

Enclosed you will find the original cover letter which explains the purpose of this research. The questionnaire and a postage paid envelope are enclosed for your convenience.

Thank you for returning the questionnaire. Your time, expertise, and information are highly valued.

Sincerely,

Alexia Green RN, MSN

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