

Risk Management Strategies for a Nursing Faculty

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Introduction

A nursing faculty, school, or department operates at the intersection of higher education and healthcare. Unlike many academic units, it must manage ordinary institutional concerns while also protecting students, faculty members, patients, clinical partners, confidential information, specialized equipment, and the reputation of the nursing profession. A failure in any of these areas can interrupt teaching, harm a patient, expose a student to injury, damage an institutional partnership, create legal liability, or place a program's accreditation at risk.

Risk in nursing education should not be understood only as the possibility of financial loss. It is any uncertain event or condition that may prevent the faculty from achieving its academic, clinical, ethical, operational, or strategic objectives. The International Organization for Standardization identifies risk management as a structured process involving risk identification, analysis, evaluation, treatment, monitoring, and communication. It also emphasizes that risk management should be integrated into governance, planning, decision-making, and organizational culture rather than treated as a separate administrative exercise (International Organization for Standardization [ISO], 2018).

For a nursing faculty, effective risk management means anticipating what could go wrong before harm occurs. It also means recognizing that no institution can eliminate every risk. Clinical education, simulation, laboratory practice, research, digital learning, and community engagement all contain some uncertainty. The purpose of risk management is therefore not to create a risk-free faculty. Its purpose is to identify unacceptable threats, reduce preventable harm, prepare for unavoidable disruptions, and make informed decisions about the risks that remain.

This essay examines the major risks facing a nursing faculty and evaluates the principal strategies available for managing them. These strategies include risk avoidance, mitigation, transfer, acceptance, preparedness, and continuous monitoring. It argues that an effective nursing-faculty risk program must combine these treatment strategies with clear leadership, a reliable reporting culture, documented controls, regular training, and evidence-based evaluation.

The Nature of Risk in Nursing Education

The responsibilities of a nursing faculty extend beyond delivering lectures and grading assignments. Students must develop clinical competence, interact with patients, use equipment, administer or

simulate medications, document care, protect confidential information, and communicate with multidisciplinary teams. Faculty members must supervise these activities while meeting professional, institutional, accreditation, and legal requirements.

The American Association of Colleges of Nursing identifies quality and safety, systems-based practice, informatics, interprofessional partnerships, professionalism, and personal and professional development among the essential domains of nursing education. These domains show that nursing programs are responsible not only for transferring knowledge but also for preparing graduates to practise safely within complex healthcare systems (American Association of Colleges of Nursing [AACN], 2026).

Similarly, the Commission on Collegiate Nursing Education evaluates nursing programs in relation to their governance, institutional resources, curriculum, teaching practices, and achievement of program outcomes. Accreditation is therefore closely connected to risk management. Weak assessment systems, inadequate faculty resources, poor clinical oversight, or failure to demonstrate student achievement may threaten educational quality and accreditation status (Commission on Collegiate Nursing Education [CCNE], 2024).

The risks facing a nursing faculty can be grouped into several broad categories:

1. Clinical and patient-safety risks, including medication errors, inadequate supervision, infection exposure, or unsafe student practice.
2. Occupational health risks, such as needlestick injuries, contact with bloodborne pathogens, physical injury, or workplace violence.
3. Academic risks, including weak curricula, inconsistent assessment, academic dishonesty, unfair grading, and failure to meet accreditation standards.
4. Operational risks, such as equipment failure, shortages of faculty members, loss of clinical placements, information-system outages, or interrupted classes.
5. Legal and ethical risks, including negligence, discrimination, privacy violations, inappropriate faculty-student relationships, and failures in due process.
6. Financial risks, including property loss, legal claims, unexpected replacement costs, and inefficient use of resources.
7. Cybersecurity and information risks, including ransomware, unauthorized access, accidental disclosure, and loss of academic or clinical data.
8. Reputational risks, which may arise when an adverse event damages public confidence, student recruitment, clinical partnerships, or community trust.

These risks are interconnected. For example, an improperly maintained simulation device may first appear to be an equipment problem. If it produces inaccurate readings during student training, however, it may also become an educational-quality risk. If the fault contributes to an injury, it becomes a safety and legal risk. If the incident is poorly managed and publicized, it may also become a reputational risk.

Establishing a Risk-Management Process

Risk management should begin with a systematic assessment rather than with isolated reactions to individual incidents. The faculty should first establish its objectives, such as protecting patients, maintaining accreditation, ensuring fair student progression, sustaining clinical partnerships, and providing a safe learning environment.

Leaders can then identify events that may prevent those objectives from being achieved. Useful methods include incident reports, student complaints, faculty consultations, equipment-maintenance records, accreditation findings, clinical-partner feedback, cybersecurity assessments, near-miss reports, and emergency exercises.

Each identified risk should be assessed according to at least two factors:

- Likelihood: How probable is the event?
- Impact: How serious would the consequences be?

A low-probability event may still require urgent action when its potential impact is catastrophic. For example, the probability of a major fire in a simulation laboratory may be relatively low, but its possible consequences justify fire-prevention controls, evacuation procedures, insurance, and emergency drills.

The faculty should record significant risks in a risk register. A useful register identifies the risk, its causes, possible consequences, existing controls, likelihood, impact, assigned owner, required action, deadline, and current status. Assigning an owner is important because a risk that belongs vaguely to “everyone” may receive attention from no one.

Risk-Avoidance Strategy

Risk avoidance involves discontinuing, rejecting, or redesigning an activity because its potential consequences are unacceptable. It is generally appropriate when a risk has both a serious potential impact and no practical control capable of reducing it to an acceptable level.

For example, a nursing faculty should not purchase computers, laboratory instruments, or simulation devices that fail technical, safety, accessibility, or cybersecurity requirements. Avoiding the purchase prevents the institution from introducing a known weakness into its operations. However, this decision should be based on evidence rather than on an unverified claim that equipment is “faulty.”

Appropriate procedures include vendor evaluation, technical specifications, product demonstrations, warranty checks, cybersecurity review, acceptance testing, and confirmation that replacement parts and support are available.

Risk avoidance may also involve:

- Cancelling a clinical placement where students cannot receive appropriate supervision.
- Prohibiting students from performing procedures beyond their verified competence.
- Rejecting a research project with an ethically unacceptable risk-to-benefit ratio.
- Removing obsolete or recalled equipment from service.
- Discontinuing an online platform that cannot protect confidential information.
- Refusing to increase student enrolment when adequate faculty members, placements, or laboratory resources are unavailable.

Avoidance is powerful because it removes the source of a risk. Nevertheless, it also has limitations. Excessive avoidance may restrict innovation, reduce educational opportunities, or make a program unable to fulfil its mission. A faculty cannot avoid all clinical contact simply because healthcare involves risk. Instead, it must determine which risks are inherent and manageable and which are unnecessary or intolerable.

Risk-Mitigation Strategy

Risk mitigation reduces either the likelihood that an adverse event will occur or the seriousness of its consequences. It is the most frequently used strategy in nursing education because many essential activities cannot be eliminated.

Clinical education is a clear example. Students must practise nursing skills, but the faculty can reduce the associated risks through competency assessment, supervision, orientation, clear scope-of-practice rules, preclinical simulation, medication checks, infection-control education, and procedures for reporting errors and near misses.

The World Health Organization defines patient safety in terms of organized cultures, procedures, behaviours, technologies, and environments that reduce avoidable harm. Its global goal includes creating “a world in which no one is harmed in health care” (World Health Organization [WHO], 2021). This principle is directly relevant to nursing education because today’s students participate in care while preparing to become tomorrow’s licensed professionals.

Clinical and Infection-Control Measures

Nursing students and clinical faculty may encounter blood, body fluids, sharps, infectious diseases, hazardous medications, and contaminated equipment. Risk controls should include written exposure plans, appropriate personal protective equipment, safe sharps practices, hand hygiene, vaccinations where required, post-exposure procedures, and regular training.

The Occupational Safety and Health Administration’s Bloodborne Pathogens Standard addresses exposure-control plans, universal precautions, engineering controls, personal protective equipment, hepatitis B vaccination, post-exposure evaluation, training, and recordkeeping. These measures

provide an important model for nursing faculties and their clinical partners (Occupational Safety and Health Administration [OSHA], n.d.).

The Centers for Disease Control and Prevention further recommends job-specific infection-prevention training before personnel perform relevant duties, annual refresher training, and additional education when new equipment, procedures, or infection threats emerge (Centers for Disease Control and Prevention [CDC], 2024).

These controls should not exist only in policy manuals. Faculty members should observe whether students can correctly apply them during simulation and clinical practice. Competence requires demonstration, feedback, correction, and reassessment.

Simulation as a Risk-Control Strategy

Simulation allows students to practise difficult or high-risk procedures without initially exposing real patients to inexperienced performance. It can be used to teach medication administration, emergency response, communication, delegation, infection control, clinical judgment, and teamwork.

The Agency for Healthcare Research and Quality reports that simulation can improve technical skills, teamwork, safety culture, and preparation for adverse events. It may also be used to recreate an actual event, identify contributing factors, and test whether corrective actions are effective (Agency for Healthcare Research and Quality [AHRQ], 2024).

Simulation does not remove the need for direct clinical experience. It reduces risk when used deliberately and followed by structured debriefing. Faculty members must also verify that simulation equipment is maintained, scenarios are educationally appropriate, facilitators are trained, and students receive psychologically safe feedback.

Equipment Maintenance

Routine inspection and maintenance of nursing and simulation equipment are essential mitigation measures. Devices such as defibrillator trainers, medication pumps, hospital beds, oxygen equipment, mannequins, computers, and laboratory instruments may become unsafe or inaccurate when they are damaged, improperly calibrated, or used beyond their service life.

A faculty should maintain an inventory that identifies:

- The equipment owner or responsible department.
- Purchase and installation dates.
- Manufacturer instructions.
- Inspection and maintenance schedules.
- Calibration requirements.

- Reported faults and repairs.
- Software and security updates.
- Removal-from-service criteria.
- Replacement dates.

A warning label alone is not an adequate response to seriously defective equipment. A potentially unsafe device should be isolated from use until a qualified person has inspected, repaired, or replaced it.

Risk Transfer and Risk Sharing

Risk transfer shifts part of the financial or operational burden to another party. Insurance is the most familiar example. A university may purchase property, liability, cyber, workers' compensation, professional liability, vehicle, or business-interruption coverage.

Insurance can help pay certain losses, but it does not eliminate the event itself. It cannot reverse patient harm, restore a damaged reputation immediately, guarantee continued accreditation, or remove leaders' ethical responsibilities. For this reason, insurance should complement prevention rather than replace it.

Other forms of risk transfer or sharing include:

- Requiring suppliers to provide warranties and maintenance guarantees.
- Using contracts that clearly allocate responsibilities between the faculty and clinical partners.
- Requiring service providers to meet privacy and cybersecurity conditions.
- Using qualified external contractors for specialized equipment maintenance.
- Establishing indemnification provisions where legally appropriate.
- Sharing emergency-planning responsibilities with the wider university and community agencies.

Contracts should be reviewed by authorized legal and risk-management professionals. Poorly drafted transfer provisions can create a false sense of security or shift obligations in ways that conflict with professional, legal, or accreditation requirements.

Risk Acceptance and Contingency Planning

Some risks cannot be avoided, economically transferred, or reduced further. A faculty may consciously accept such a risk when its remaining level is within the institution's approved tolerance.

Acceptance should never mean ignoring a problem. It should be a documented decision based on analysis. The faculty should understand the likely consequences, identify the person authorized to accept the risk, and establish contingency measures.

For example, a temporary failure of a nonessential simulation device may be acceptable when alternative equipment is available and patient care is not involved. The faculty might continue teaching through a revised exercise while arranging repair. In contrast, continuing to use a device known to produce unsafe or inaccurate results would not represent responsible acceptance.

Contingency planning is particularly important for:

- Information-system outages.
- Severe weather and natural disasters.
- Faculty illness or sudden staffing shortages.
- Loss of a clinical placement.
- Power failures.
- Infectious-disease outbreaks.
- Cyberattacks.
- Building closures.
- Disruption of supply chains.

The U.S. Department of Education recommends that institutions of higher education use a continuing planning process to assess hazards, develop emergency operations plans, assign responsibilities, coordinate with community partners, and revise plans through exercises and experience (U.S. Department of Education, 2022).

Academic Quality and Accreditation Risk

A nursing faculty may operate without a major physical accident and still face serious risk if its graduates do not achieve expected competencies. Academic risk arises when curricula are outdated, assessment methods are unreliable, faculty qualifications are inadequate, student progression decisions are inconsistent, or outcome data are ignored.

The CCNE accreditation process examines institutional commitment, resources, curriculum, teaching practices, governance, and program outcomes. It treats accreditation as a process of accountability and continuous quality improvement rather than a one-time inspection (CCNE, 2024).

Controls for academic-quality risk should include:

- Systematic curriculum review.
- Mapping course outcomes to professional competencies.
- Consistent assessment rubrics.
- Reliable examination procedures.
- Documentation of student competence.
- Faculty-development programs.
- Analysis of completion, licensure, employment, and progression data.

- Formal procedures for student complaints and appeals.
- Regular consultation with students, graduates, employers, and clinical partners.
- Prompt corrective action when outcomes fall below established benchmarks.

The faculty should avoid manipulating data or lowering standards merely to produce attractive completion rates. Risk management protects educational integrity when it reveals weaknesses honestly and supports improvement.

Faculty Workforce and Workload Risk

The quality of a nursing program depends heavily on the availability, competence, and well-being of its faculty. Excessive workload, vacancies, burnout, weak succession planning, and dependence on a small number of individuals can affect supervision, grading, curriculum development, research, student support, and accreditation.

AACN reported that 1,588 full-time faculty vacancies were identified among responding U.S. nursing schools in its October 2025 survey, producing a national vacancy rate of 7.2%. It also reported that nursing schools turned away more than 80,000 qualified applications in 2024 because of constraints that included faculty, clinical sites, preceptors, classroom capacity, and budgets (AACN, 2026).

A nursing faculty can mitigate workforce risks by:

- Monitoring workload across teaching, clinical supervision, service, and research.
- Developing succession plans for leadership and specialized courses.
- Creating mentorship programs for new educators.
- Supporting continuing professional development.
- Using qualified adjunct faculty without becoming excessively dependent on them.
- Maintaining backup teaching and clinical-supervision arrangements.
- Reviewing compensation, recognition, promotion, and retention practices.
- Providing support after stressful clinical or student-related incidents.
- Ensuring that faculty-to-student arrangements meet regulatory and clinical-site requirements.

Ignoring workload pressures can produce more than employee dissatisfaction. It may contribute to delayed feedback, inadequate supervision, errors, absence, resignation, and declining program quality.

Cybersecurity and Privacy Risk

Nursing faculties store valuable information, including student records, assessment results, research data, clinical-placement documents, health-clearance records, video recordings, and sometimes patient-related information used in education or research.

The Family Educational Rights and Privacy Act protects qualifying student education records in the United States. When students work in clinical settings, additional privacy and contractual obligations may apply to patient information. A careless photograph, unsecured spreadsheet, lost device, misdirected email, or improperly accessed electronic record can therefore create significant harm.

The National Institute of Standards and Technology organizes cybersecurity risk around six functions: govern, identify, protect, detect, respond, and recover. This framework is useful for nursing faculties because cybersecurity depends on leadership, human behaviour, technology, incident response, and recovery rather than on antivirus software alone (National Institute of Standards and Technology [NIST], 2024).

Appropriate controls include multifactor authentication, role-based access, secure backups, device encryption, privacy training, phishing awareness, timely software updates, vendor review, restrictions on personal devices, incident-reporting procedures, and tested recovery plans.

Practical Risk-Treatment Table

Risk	Possible consequences	Primary treatment	Examples of controls
Unsafe clinical placement	Patient harm, student injury, liability	Avoidance and mitigation	Placement review, qualified supervision, withdrawal from unsafe site
Needlestick injury	Infection exposure, distress, treatment costs	Mitigation and transfer	Sharps controls, PPE, training, post-exposure plan, insurance
Defective simulation equipment	Injury, inaccurate learning, interruption	Avoidance and mitigation	Acceptance testing, maintenance, calibration, removal from service
Faculty shortage	Reduced enrolment, excessive workload, poor supervision	Mitigation and contingency	Recruitment, retention, succession planning, backup staffing
Loss of clinical sites	Delayed progression, reduced admissions	Mitigation and sharing	Multiple partnerships, simulation, early contract review

Risk	Possible consequences	Primary treatment	Examples of controls
Data breach	Privacy violations, legal action, reputational damage	Mitigation and transfer	Access controls, encryption, cyber insurance, incident response
Accreditation deficiency	Sanctions, declining enrolment, loss of confidence	Mitigation	Continuous outcome assessment, curriculum review, documented improvement
Fire, disaster, or building closure	Injury and interruption of teaching	Mitigation, transfer, and contingency	Emergency plan, drills, insurance, alternative teaching arrangements
Minor unavoidable disruption	Temporary delay or inconvenience	Acceptance	Documented approval, monitoring, backup procedure

Creating a Culture of Reporting and Learning

Policies alone cannot manage risk when students and employees are afraid to report problems. A strong safety culture encourages the early reporting of hazards, near misses, mistakes, equipment faults, privacy concerns, and unsafe conditions.

This does not mean eliminating accountability. Reckless or intentional misconduct requires an appropriate response. However, honest human error should also prompt an examination of workload, communication, supervision, training, equipment, procedures, and system design.

A near miss is especially valuable because it reveals a weakness before serious harm occurs. For example, if a student nearly administers the wrong simulated medication because two packages look similar, the faculty should examine the labeling, storage process, instructions, supervision, and assessment method. Simply warning the student may leave the underlying hazard unchanged.

Leaders strengthen risk culture when they respond consistently, communicate lessons without unnecessary blame, protect confidentiality, and demonstrate that reporting produces improvement.

Conclusion

Risk management in a nursing faculty is not limited to buying insurance or avoiding defective equipment. It is a continuous process through which the faculty protects students, employees, patients, educational standards, confidential information, physical resources, and institutional trust.

Risk avoidance is appropriate when an activity presents an unacceptable and unnecessary danger. Mitigation is necessary when essential activities contain risks that can be reduced through training, supervision, maintenance, simulation, infection control, and reliable procedures. Risk transfer can reduce the financial consequences of selected events, but it cannot transfer every ethical, legal, or reputational responsibility. Risk acceptance is appropriate only when the remaining risk has been evaluated, authorized, monitored, and supported by contingency plans.

The most effective approach combines these strategies within an integrated governance structure. The faculty should maintain a risk register, assign accountable owners, assess likelihood and impact, track corrective actions, examine near misses, review emerging threats, and report significant concerns to institutional leaders.

Ultimately, a well-managed nursing faculty does more than prevent loss. It models the professional values that students will be expected to carry into healthcare practice. By treating safety, accountability, evidence, and continuous improvement as shared responsibilities, the faculty strengthens both nursing education and the quality of care its graduates will eventually provide.

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