

**Just Culture**  
**Student Practice Event Evaluation Tool**  
**for**  
**Nursing Education Programs**

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**2012**



# North Carolina Board of Nursing Mission Statement

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**The mission of the North Carolina Board of Nursing is to protect the public by regulating the practice of nursing.**

**(January 2010)**



# Traditional Regulatory and Disciplinary Models

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- Retrospective
- Reactive
- Blame placed at “sharp end”
- Severity of punishment dependent on severity of the outcome

# Introduction to Just Culture

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**The single greatest impediment to error prevention in the medical industry is “that we punish people for making mistakes”**

Dr. Lucian Leape

Professor, Harvard School of Public Health

Testimony before Congress on  
Health Care Quality Improvement



# Introduction to Just Culture

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*“On one side of the coin, it is about creating a reporting environment where staff can raise their hand when they have seen a risk or made a mistake. On the other side of the coin, it is about having a well-established system of accountability. A ‘Just Culture’ must recognize that while we as humans are fallible, we do have control of our behavioral choices.”*

David Marx, Outcome Engineering



# Just Culture Background

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- **“Managing the Risks of Organizational Accidents” – Reason (1997)**
- **“To Err is Human” - IOM (1999)**
- **“Patient Safety and the Just Culture-A Primer for Health Care Executives” - Marx (2001)**

# Cornerstones of a Just Culture

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## Create a Learning Culture

- Eager to recognize risk at both the individual and organizational level.
- Risk is seen through events, near misses, and observations of system design and behavioral choices.
- Without learning we are destined to make the same mistakes.

# Cornerstones of a Just Culture

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## Create an Open and Fair Culture

- Move away from an overly punitive culture and strike a middle ground between punitive and blame free.
- Recognize human fallibility:
  - Humans will make mistakes.
  - Humans will drift away from what we have been taught.

# Cornerstones of a Just Culture

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## Design Safe Systems

- Reduce opportunity for human error.
- Capture errors before they become critical.
- Allow recovery when the consequences of our error reaches the patient
- Facilitate individuals making good decisions.

# Cornerstones of a Just Culture

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## Manage Behavioral Choices

- **Humans will make mistakes**
  - We must manage behavioral choices in a way that allows us to achieve the outcome we desire.
- **Cultures will drift to unsafe places**
  - We must coach each other around reliable behaviors.

# Introduction to Just Culture

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## A Just Culture ....

- Supports an Open, Fair, Learning Culture
- Practices Proactive Management of System Design
- Focuses on Management of Behavioral Choices
- Maintains both Personal and System Accountability

# Introduction to Just Culture

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In a Just Culture we believe ...

- To Err is Human
- To Drift is Human
- Risk is Everywhere
- We Must Manage in Support of Our Values
- We Are All Accountable

# Introduction to Just Culture

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## The Three Types of Expected Behaviors

- **Human Error:** an inadvertent action; inadvertently doing other than what should have been done; a slip, lapse, or mistake.
- **At-Risk Behavior:** a behavioral choice that increases risk where risk is not recognized, or is mistakenly believed to be justified.
- **Reckless Behavior:** a behavioral choice to consciously disregard a substantial and unjustifiable risk.

# Introduction to Just Culture

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## How We Manage Behaviors

### **Human Error: Console**

- Change processes, procedures, training, design, environment as indicated

### **At-Risk Behavior: Coach**

- Remove incentives for at-risk behaviors, create incentives for healthy behaviors, increase situational awareness

### **Reckless Behavior: Punish**

- Disciplinary action; Remedial action

# NCBON Just Culture

## Student Practice Event Evaluation Tool

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- *Provides a mechanism for Nursing Education Program Directors/Faculty and the regulatory board to come together to promote a just culture that promotes learning from student practice errors*
- *Properly assigns accountability for behaviors*
- *Consistently evaluates events*

# Just Culture and Nursing Student Events

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- Consistent with NC BON Strategic Initiative to promote “Just Culture” model for accountability
- Nursing Programs use Student Practice Event Evaluation Tool (SPEET) to evaluate student practice events/incidents and determine appropriate actions
- Differentiate incidents resulting from human error from those resulting from at-risk and reckless behaviors
- Focus on behavioral choices or level of risk, versus outcome

# **Just Culture and Nursing Student Events**

## ***Benefits of Using the SPEET***

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- 1) Provides an objective tool for evaluating nursing student practice events**
- 2) Promotes evaluation focused on behavioral choices or level of risk, versus outcome**
- 3) NC BON Education Consultants available to assist in using SPEET for consistency in program resolution of issues**
- 4) Collaboration with Education Consultant facilitates timely issue resolution in a fair, respectful way that promotes both patient safety and appropriate retention of students**

# **Just Culture and Nursing Student Events**

## ***Benefits of Using the SPEET***

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- 5) Provides Nursing Program Directors and Faculty with the assurance that adverse student practice events are resolved appropriately, fairly, and consistently.**
- 6) Provides a framework for Nursing Program Director and Faculty to consistently apply expectations for accountability and behavioral choices, while treating individuals respectfully and fairly.**
- 7) Open communication in analyzing student practice events assists both the Program and Board in understanding underlying causes and provides valuable information that can be used to guide evidence-based practice.**

# Just Culture SPEET Implementation

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- Program Directors & Faculty are educated re: Just Culture and use of the NC BON Student Practice Event Evaluation Tool (SPEET) using case scenarios
- Participants are encouraged to use the SPEET to assess all nursing student practice events and to retain completed tools in student files
- Participants are encouraged to consult with Board Education Consultants as needed
- ***Programs retain full control of all student intervention decisions in accordance with Educational Institution Policies***

# Just Culture “Toolbox”

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- **Guidelines for Student Practice Event Evaluation Tool (SPEET) Use and Consultation with the Board**
  - scoring
  - mitigating factors
  - aggravating factors
  - documentation and submission
  
- **Examples of:**
  - human error
  - at-risk behavior
  - reckless behavior
  - systems issues

# Event Resolution Options

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- 1) **Human Error – Program Director & Faculty support and *counsel* student; remedial plan is developed if indicated**
- 2) **At-Risk Behavior – Program Director & Faculty *coach* student and possibly counsel; remedial improvement plan is developed with student; *actions adhere to Program and Educational Institution policies and directives***
- 3) **Reckless Behavior – Program Director & Faculty consider disciplinary action and/or remedial action in addressing event with student; *actions adhere to Program and Educational Institution policies and directives***
- 4) **System Issues Contributing to Event - Program Director & Faculty address program-related and clinical setting system issues**

# NCBON SPEET Desired Outcomes

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- **Develop a common framework for review of student practice events that lends itself to:**
  - appropriate, fair, and consistent event resolution;
  - consistent application of expectations for accountability and behavioral choices; and
  - continuous quality improvement.
- **Balance non-punitive learning with individual and system accountability while promoting appropriate retention of nursing students.**
- **Enhance patient safety by understanding underlying causes of events and using information to guide evidence-based practices.**

# Scenarios

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# Scenario One

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- A nursing student is participating in clinical experience on a medical/surgical unit for the 7am to 3 pm shift. The facility uses traditional time with the hours recorded as AM or PM. Lexapro 10 mg is ordered to be administered by mouth to Mrs. Jones at 9:00 PM.
- The student administers Lexapro 10 mg by mouth at 9:00 AM rather than 9:00 PM.
- The student does not have prior disciplinary action. The student recognizes the error and self-reports to the instructor. The patient did not experience any type of adverse outcome related to the medication error.

# Scenario Two – page 1

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- A student is in the clinical component of the Senior Practicum on a medical-surgical unit of an acute care facility. This is the student's 3rd clinical rotation on this unit. The student is assigned to three patients. Patient #1 is being discharged status-post appendectomy. Patient #2 is pre-op for fistula shunt revision in the morning. Patient #3 is a transfer from the intermediate step down unit status post cardiac ablation.
- There is a new physician order to discontinue a central line for patient number three. The preceptor is off the floor for lunch.
- The student appropriately checks physician's order and gathers supplies to discontinue the central line. The student proceeds to the patient's room and discontinues the patient's central line without preceptor or instructor supervision. The patient experiences localized tenderness at the central line insertion site.

# Scenario Two – page 2

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- The student has not demonstrated skill competency in discontinuation of central lines prior to performing this skill. The nursing student handbook and preceptor handbook state all skills are to be performed under the supervision of the preceptor or nursing faculty.
- The student does not have prior disciplinary action. When questioned about the incident, the student agrees he acted without supervision of the preceptor, but thought it more important to remove the central line to decrease the patient's risk of infection.

# Scenario Three – page 1

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- A student is in the final semester course of her senior year. She is assigned 3 patients on a medical unit of an acute care facility. This is the student's second rotation on this unit. Patient #1, a 41 year old, admitted for fever of unknown origin and dehydration, is stable. Patient #2, a 57 year old status post bowel resection, is up ambulating, and stable. Patient #3 is a 76 year old male with the diagnosis of pneumonia.
- During the student's morning assessment of patient #3, the patient exhibited:
  - \*tachypnea at 42 breaths/minute,
  - \*pursed lip breathing,
  - \*diaphoresis,
  - \*capillary refill 5 seconds, and
  - \*diffuse wheezing throughout the lung fields upon auscultation of breath.

# Scenario Three – page 2

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- Patient #3 has orders for:
  - \*albuterol treatments every six hours and PRN,
  - \*begin 2 L oxygen if oxygen saturation is less than 90%
- After completion of the routine morning assessment on patient #3, the student proceeded with completion of the routine morning assessment of the other two assigned patients. The student did not provide a STAT albuterol treatment, measure oxygen saturation, or report the patient's condition to the nurse/instructor. The patient did not experience any type of adverse outcome related to this incident.
- The student does not have prior disciplinary action. When the incident was discussed with the student, the student stated “It is important that I get all of my assessments done on time so that I don't get behind in my work”.

# Scenario Four

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- A student in a generic nursing program was assigned an observational experience in outpatient surgery. While there, a CRNA was explaining/showing the student about intubations and in doing so told the student to "take this tube & put it in there" referring to intubating a patient. The student took the tube and tried to do as instructed. When the "tube" wouldn't "go", the anesthesiologist came over, took another "tube", handed it to the student and guided her to intubate the patient.
- When the OR staff saw this happen, the student was removed from OR and the instructor was called to the OR supervisor's office. When confronted, the student didn't understand what was going on. She stated she only did what the CRNA and the anesthesiologist told her to do. Once she realized she "messed up", she became obviously upset. She had only been in the program for 10 days and had had no prior issue/practice plan or discipline. No harm to the patient was reported.

# Scenario Five – page 1

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- Student B began a nursing program in the Fall. During Spring Semester, she voiced in a public area on campus that she had learned how to access the grades of other students through Blackboard. Student C overheard the comment and reported it to the Program Director. Student C did not think it was right for another student to see her grades and asked that the Program Director look into the matter.
- Upon an investigation, it was not only discovered that Student B had accessed 2 students Blackboard accounts and checked their grades (one during fall semester and one during the spring semester) but 3 months ago, she had also viewed the electronic medical records at a clinical site for 2 patients to whom she was not assigned.

# Scenario Five – page 2

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- During a meeting with the student, she admitted to being "curious & nosey" about other students' grades but did not remember accessing the patient records. However, an audit showed she viewed 3 screens on 2 different patients. The student had been counseled during Fall semester about "sticking her nose where it didn't belong", in a situation involving another student. She was given a warning about "being nosy".
- When initially approached, she denied accessing both the students grades and any clinical information for any patient that she was not assigned. When confronted with evidence and following direct questioning, she admitted to her wrongdoing in accessing the students grades, but said that the viewing of clinical records was "by accident". She never told her instructor or any one else that it had happened. When asked why she had lied, she stated "I didn't want to get into trouble". She denied sharing the clinical information with anyone.

# Scenario Six – page 1

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- A senior student in the next to the last week of the final nursing course in the curriculum administered 1 ml of regular insulin instead of 1 unit. The error was discovered when the patient's level of consciousness changed and he evidenced other signs of severe hypoglycemia. The student stated that she used the only syringe that she could find when she was preparing the medication and that she needed to administer it "on time". The syringe she used was a regular 3ml syringe. The preceptor intervened and the patient had no lasting negative effects from the insulin overdose.
- The student was in a precepted experience. Her preceptor was on the unit but did not check the insulin that the student had prepared prior to it being administered. There was no policy in place at the clinical agency that required a second person check high risk medications prior to administration. There was no policy in place at the school that required students to have medications checked prior to administration if they had been "checked off" on medication administration in the course.

# Scenario Six – page 2

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- The faculty member responsible for the student in this course had not formally made rounds on this student while she was in clinical for the last two weeks. When approached by the program director, the faculty member stated that the preceptor would call if there was a problem.
- The preceptor had notified the faculty member via email two weeks prior to this event that the student had administered the incorrect dose of SQ Heparin to a patient. There was no untoward patient result but the preceptor, not the student, picked up the error.
- The student had been formally counseled for 4 other performance events other than the events of this semester: 2 in her junior year and 2 in the semester prior to the semester in which this event occurred. 2 of the issues involved medication errors; 1 involved inadequate assessment/recognition of changes in patient clinical status; 1 involved repeated breaks in infection control protocols when caring for a patient in isolation. The student's theory average for this course was 92.

# Why Just Culture matters...

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- Changing healthcare environment
- Finite amount of resources
- Efficiency, effectiveness, fairness
- Need to do the right “things”, not just do things “right”

# Now Tell Us....

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- **Concerns**
- **Issues**
- **Questions**



# Resources and Contacts

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Telephone: (919) 782-3211

## Primary SPEET Consultation Resources:

- Crystal Harris, RN, MSN, CPNP                      Ext 263  
[charris@ncbon.com](mailto:charris@ncbon.com)
- Janet Arthurs, RN, MSN, EdD                      Ext 251  
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## Secondary SPEET Consultation Resources:

- Joyce Roth, RN, MSN                      Ext 269  
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- Linda Burhans, RN, PhD                      Ext 265  
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