“Just Culture”
In
Nursing Regulation

COMPLAINT EVALUATION TOOL (CET)
INSTRUCTION BOOKLET

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"Just Culture" in Nursing Regulation Toolbox

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Just Culture Talking Points

David Marx, a systems engineer with a juris doctor in law, is well known for his work in patient safety and safe system design. Marx describes “Just Culture” as follows:

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.

Asked to describe what he does in one sentence, David Marx will tell you that he and his colleagues work to keep clients from inadvertently killing their customers! From aviation to healthcare, David has spent his adult life helping others reduce the risks imposed on us all by our shared human fallibility. Through his work as founder and CEO of The Just Culture Company, LLC (previously Outcome Engenuity) a risk management firm, David’s efforts can be seen in the safety practices of high-risk industries around the world.

The Just Culture Company, LLC “Just Culture” Algorithm developed by David Marx is used for evaluating events and determining whether the actions of the individual warrant consoling, counseling, remediation, or punishment. This tool can be used by employers, regulatory boards, and others to evaluate an incident with consistency and fairness, while providing the opportunity to learn from mistakes and enhance patient safety.

The principle behind a “Just Culture” is this: Discipline needs to be tied to the behavioral choices of individuals and the potential risks their behavioral choices present rather than be dependent upon the actual outcome of their actions.

A “Just Culture”:

- Places focus on evaluating the behavior and choices made by an individual, not on the outcome of the event;
- Requires leadership commitment and modeling;
- Distinguishes among normal human error, unintentional risk-taking behavior, intentional risk-taking behaviors, and reckless behaviors;
- Fosters a learning environment that encourages reporting (including self-reports) of all near misses, mistakes, errors, adverse events, and system weaknesses;
- Lends itself to continuous improvement of work processes and systems to ensure the highest level of client and staff safety;
- Encourages the use of non-disciplinary actions whenever appropriate (including coaching, counseling, training, and education); and,
- Holds individuals accountable for their own performance in accordance with their job responsibilities but does not expect individuals to assume accountability for system flaws over which they had no control.

“Just Culture” encourages discussion and reporting of errors and near misses without fear of retribution. It is a culture that focuses on the behavioral choices of the practitioner, not merely on the fact that an error occurred or that a bad outcome resulted from an error.

“Just Culture” recognizes that perfect performance is not something that can be sustained, and errors will occur. It recognizes that the threat of disciplinary action does NOT prevent individuals from making errors.

In a “Just Culture” there is agreement that even the most experienced and careful individual can make a mistake that could lead to client risk or harm. There is recognition that individuals will make mistakes and that perfect performance is impossible.

“Just Culture” is **not** a “blame-free” response to all errors. It focuses on the behavioral choices of the individual, the degree of risk-taking behavior, and whether the individual deliberately disregarded a substantial risk. It holds the individual accountable who makes unsafe or reckless choices that endanger clients or others.

“Just Culture” has been introduced in many healthcare organizations and in multiple states having statewide patient safety initiatives. Along with the NC Board of Nursing, the NC Center for Hospital Quality and Patient Safety was an early adopter of “Just Culture” principles. The Center facilitates collaborative projects among hospitals interested in implementing “Just Culture” in North Carolina.

In embracing and supporting “Just Culture” principles, the NC Board of Nursing implemented several pilot projects to partner with participating healthcare facilities to promote consultation and discussion of events in a positive manner. The pilots demonstrated that a Board- developed Complaint Evaluation Tool (CET), based on the “Just Culture” Algorithm, assisted employers in identifying events that could be addressed in the practice setting versus those that would benefit from board consultation or would require formal report to the Board.

The Board’s commitment to “Just Culture” principles and use of the Complaint Evaluation Tool now provides a mechanism for employers of nurses and the regulatory board to come together to promote a “Just Culture” that promotes learning from practice errors while properly assigning accountability for behaviors, consistently evaluating events, and complying with mandatory reporting requirements.

NC Board of Nursing "Just Culture" Overview

The North Carolina Board of Nursing (NCBON) offers healthcare facilities the opportunity to partner in promoting consultation and discussion of events in a positive manner. The purpose of this NCBON approach is to provide a mechanism for employers of nurses and the regulatory board to come together to develop a culture that promotes learning from practice errors while properly assigning accountability for behaviors, consistently evaluating events, and complying with mandatory reporting requirements.

Since the 1999 Institute of Medicine Report, "To Err is Human", much attention has been placed on patient safety and the incidence of error. We were told that as many as 180,000 deaths occur in the United States each year due to errors in health care. Subsequent reports revealed significantly higher error rates. It is inevitable that nurses make mistakes in today's complex and interdependent health care environment. Most errors take place within complex systems. When errors occur, however, the immediate solution is often to blame an individual for the error. Blaming individuals creates a culture of fear, discourages open reporting and discussion of errors, and does little to prevent future errors or improve the safety of the health care system.

Only through promoting a culture that supports critical analysis, constructive feedback and productive dialogue will we ever be able to learn from errors and improve safe patient care.
In order to move toward a fair and "Just Culture", where learning can occur, we must provide a forum where errors or unanticipated outcomes can be used as the basis for a learning process, rather than grounds for punishment.

North Carolina is a "mandatory" reporting state, meaning that nurses and others are required to report to the Board any suspected violations of the Nursing Practice Act. The NCBON has made concerted and consistent efforts to move away from a culture of blame and shame and toward a culture of quality improvement with an emphasis on patient safety.

Consistent with our strategic initiative to collaborate with others to promote a learning culture that supports patient safety, NCBON adopted a "Just Culture". This provides that forum where the NCBON "Just Culture" Complaint Evaluation Tool (CET) can guide the employer and the Board in review of practice errors or deficiencies in partnership, focusing on resolutions that promote practice enhancement and patient safety.

Healthcare facilities are provided contact information for NCBON RN Consultants in the Education and Practice Department to facilitate consultation and review of events using the NCBON CET. Consultants work with nurse managers or designated staff within healthcare facilities; provide informal discussion and problem-solving related to practice issues; and provide on-site training in use of the CET if requested.

The NCBON website (www.ncbon.com) provides the following resources:

- Complaint Evaluation Tool (CET)
- CET Training Booklet
- Guidelines and forms for formal reporting when necessary
- Consultant contact information

As healthcare facility staff and NCBON staff discuss events, they jointly utilize the NCBON "Just Culture" Complaint Evaluation Tool (CET), so that matters are handled as consistently as possible. We believe that it serves no purpose to punish individuals for honest mistakes, systems issues, or lack of knowledge or experience. The NCBON CET serves as the basis for all complaint reporting decisions. It is our hope that lessons learned can be generalized and spread within healthcare facilities, throughout North Carolina, and across other states.

References:

Kohn L, Corrigan, J, Donaldson M, eds. Committee on Quality of Health Care in America, Institute of Medicine. (1999). *To Err is Human: Building a Safer Health Care System.* Washington, DC: National Academy Press.

Marx, D. (2001). *Patient safety and the "Just Culture": A primer for health care executives.* Prepared for Columbia University under a grant provided by the National Heart, Lung, and Blood Institute (April 17, 2001). Retrieved August 16, 2008 from http://www.mers-tm.net/support/Marx Primer.pdf

Marx, D. (2009). *Whack-a-mole: The price we pay for expecting perfection.* Plano, TX: By Your Side Studios.

Guidelines for Evaluating and Reporting Practice Events to the North Carolina Board of Nursing

In fulfilling its mission to safeguard the public health, safety, and welfare, the Board is committed to nursing practice regulation that is prompt, fair, and appropriate to public protection. The Board believes protection of the public can be facilitated by fair and just treatment of nurses who are involved in practice events. The Board reacts promptly to complaints and allegations of violations of the Nursing Practice Act and Rules. All allegations are evaluated with respect to the merits of the individual case and the potential risk to the public. The Board's responses to substantiated violations fall within a continuum of remedial and disciplinary action.

The Board believes protection of the public is not enhanced by the reporting of every one-time minor event or incident that may be a violation of the North Carolina Practice Act. Employers may be able to be the first line of intervention in addressing violations that pose little ongoing risk to the public. In these situations, employers may be able to address deficits in a nurse's behavior and practice including judgment, knowledge, training, or skill in collaboration with the Board. This is particularly true when there are mechanisms in place in the nurse's practice setting to:

- identify near misses and nursing errors,
- detect patterns of practice,
- take corrective action, and
- monitor the effectiveness of remediation.

Non-Reportable Events

Definition: Employee has failed to follow employment (not clinical practice) policies. These events are generally not reportable as violations of the North Carolina Nursing Practice Act and therefore would not be addressed by the Board. There may, however, be circumstances that could merit the Board's attention. Nothing in these guidelines is intended to prevent or discourage direct reporting of a potential violation to the Board of Nursing. Please call the Board's Education and Practice Consultants with any questions about specific situations.

Response: Manage within organization's employment, remediation, and disciplinary policies.

Examples of Non-reportable Events:

- No Call-No Show
- Failure to complete a 2-week notice (abrupt termination)
- Refusal to accept an assignment
- Rudeness or inappropriate verbal interactions with patients or staff
- "Nodding" or falling asleep momentarily, unless this is a pattern of practice, or results in patient neglect or risk
- Falsification of employment application (unless falsification relates to licensure status)
- Failure to follow agency policy (unless this is ALSO a violation of practice act)
- Failure to submit agency paperwork in timely manner (unless this jeopardizes patient care versus reimbursement only)
- Mental/emotional problems or issues that do not impact or relate to the nurse's practice
- Information related to mental or physical conditions of a nurse, obtained while providing care for the nurse (which means information is protected)

Guidelines for Evaluating and Reporting Practice Events to the North Carolina Board of Nursing

Systems Issues

Definition: Events or issues that are primarily the result of factors beyond the nurse's control

Criteria: Some events, whether minor or significant, may be the result of or influenced by systems factors, as well as by individual factors. Organizational and nursing leaders are responsible for evaluating and addressing system impact on any incident or event, regardless of reportability. Opportunities for system improvements may exist independent of, or in conjunction with, opportunities for individual improvement.

Response: Design and implement system improvements.

Examples of Systems Issues:

- Malfunctioning equipment
- Staffing/work hour issues
- Physician/nurse communication barriers
- Outdated policies/procedures, no longer reflective of current best practice or evidence- based practice
- Inappropriate assignment practices

Reportable Events

North Carolina is a "mandatory" reporting state, meaning that nurses are required to report to the Board any suspected violations of the Nursing Practice Act. The Board's "Just Culture" approach provides a mechanism for employers of nurses and the regulatory board to come together to develop a culture that promotes learning from practice errors while properly assigning accountability for behavioral choices, consistently evaluating events, and complying with mandatory reporting requirements. As healthcare facility nursing leaders and NCBON staff discuss practice related events, they jointly utilize the NCBON "Just Culture" Complaint Evaluation Tool (CET), so that matters are handled as consistently as possible.

Nurses are responsible for being familiar with the state-specific laws and rules governing their practice. Nurse leaders, employers of nurses, and all individual nurses in NC are directed to the Board website at www.ncbon.com to review the following regarding violations of the Nursing Practice Act and NC Administrative Code Rules:

- The NC Nursing Practice Act section 90-171.37 *Discipline Authority.* This law establishes the Board's legal authority upon receipt of information about any practice that might violate any provision within the Nursing Practice Act or any rule or regulation promulgated by the Board.

- The NC Administrative Code section 21 NCAC 36 .0217 *Investigations: Disciplinary Hearings.* This rule provides detail regarding specific behaviors and activities which may result in disciplinary action by the Board. It further details the processes related to such Board actions.

Nurses sometimes have questions concerning any personal legal risk they may assume in reporting suspected violations of another nurse to the Board. This issue is addressed in:

- The NC Nursing Practice Act section 90-171.47 *Reports: immunity from suit.* This law clarifies that individuals reporting based on reasonable cause is immune from criminal prosecution or civil liability unless they knew the report was false or acted in reckless disregard of whether the report was false.

Examples of Human Error. At-Risk, and Reckless Behaviors

Human Error

Definition: Nurse inadvertently, unintentionally did something other than intended or other than what should have been done; a slip, a lapse, or an honest mistake. **Human errors are not reportable events.**

Criteria: Refer to the NCBON Complaint Evaluation Tool (CET) - Human Error Section (Green Column) - each behavior evaluated in this column is valued at 0 points.

Response: Human Error, if not a pattern of behavior, may best be addressed by consoling the nurse. Discipline is not indicated if an event was inadvertent and unintentional. If human errors of the same type are repetitive, indicating a pattern of behavior, the nurse's behavioral choices and personal performance shaping factors should be evaluated. If identified as contributing to the errors, the nurse is to be expected to address these factors and make better behavioral choices. If not correctable by changes in work choices or remedial education/training, further errors of the same type may appropriately result in disciplinary action.

It is important to remember that when human error is identified, the next step is to understand why the error occurred. Human error cannot be the end of the search for causes. This label can distract from identifying the inadequate systems we designed around our employees, or the risky behavioral choices we all made as precursors to the error. There is usually more to the story than mere human error. The underlying causes can be addressed within the system to prevent reoccurrence.

Examples of Human Error:

- Single medication event/error (wrong dose, wrong route, wrong patient, or wrong time)
- Failure to implement a treatment order due to oversight

At-Risk Behavior

Definition: Nurse makes a behavioral choice that increases risk where risk may not be recognized or is mistakenly believed to be justified; nurse does not appreciate risk; unintentional risk taking. Generally, the nurse's performance and conduct does not indicate that their continuing practice poses a risk to clients or other persons. The nurse may knowingly deviate from a standard due to a lack of understanding of the risk to the client, organization, self, or others. **At-Risk Behaviors may or may not be reportable events.**

An NCBON Education and Practice Consultant must assist in this determination of reportability.

Criteria: Refer to the NCBON Complaint Evaluation Tool (CET) - At-Risk Behavior Section (3 Yellow Columns) - each behavior evaluated in these columns is valued at 1,2, or 3 points.

Response: At-Risk Behaviors, if not a pattern of behavior, may best be addressed by coaching the nurse to raise awareness of the correct procedures and of the potential risks from failure to comply. Remedial actions taken to aid the nurse may include education, training, and assignment to activities

appropriate to the nurse's knowledge and skill. The nurse may be put on notice that improvement is a required expectation. If At-Risk Behaviors of the same or similar types are repetitive, indicating a pattern of behavior, the nurse's behavioral choices and personal performance shaping factors should be evaluated. If identified as contributing to the events, the nurse is to be expected to address these factors and make better behavioral choices. If not responsive to behavioral coaching, changes in work choices, or remedial education/training, further at-risk behavioral choices may appropriately result in disciplinary action.

At times, a nurse may knowingly make at-risk behavioral choices that deviate from a standard with full understanding of the risk to the client, organization, self, or others because of a decision that the benefit of violating the rule exceeded the risk. The choice may have been more appropriate in the given circumstance. In such cases, the nurse should be supported for the decision to violate a rule or standard.

Examples of At-Risk Behavior:

- Exceeding scope of practice
- Pre-documentation
- Minor deviations from established procedure

Reckless Behavior

Definition: Nurse makes the behavioral choice to consciously disregard a substantial and unjustifiable risk. The nurse's action or inaction is intentional and purposeful. The nurse puts own self/personal interest above that of the client, organization, or others. **Reckless Behaviors by a nurse must be reported to the Board.**

Criteria: Refer to the NCBON Complaint Evaluation Tool (CET) - Reckless Behavior Section (2 Red Columns) - each behavior evaluated in these columns is valued at 4 or 5 points.

Examples of Reckless Behavior:

- Nurse leaves workplace before completing all assigned patient/client care (and does not report to another nurse) because he has a date waiting.
- Nurse observes patient/client starting to climb over bedrails but walks away without intervening because it was not her assigned patient/client.
- Nurse makes serious medication error, realizes it when client experiences adverse reaction, tells no one, denies any knowledge of reason for change in client condition, and falsifies documentation to conceal error.

NOTE: Confidentiality, fraud, theft, drug abuse, impairment on duty, drug diversion, boundary issues, sexual misconduct, and mental/physical impairment are not appropriate for evaluation using the NCBON CET. These events/issues are conduct and health-related issues, not practice incidents or events, and MUST be reported to the NC Board of Nursing.

North Carolina Board of Nursing (NCBON)
COMPLAINT EVALUATION TOOL (CET)

Allegation(s): _____ **Licensee Name:** _____

	Criteria	Human Error	At Risk Behavior			Reckless Behavior		Score
		0	1	2	3	4	5	
G	General Nursing Practice	No prior written counseling for practice issues.	Prior written counseling for single non-related practice issue within last 12 months.	Prior written counseling for single related practice issue within past 12 months	Prior written counseling for various practice issues within the last 12 months	Prior written counseling for same practice issue within last 12 months	Prior written counseling for same or related practice issue within last 6 months with minimal to no evidence of improvement	
U	Understanding / level of experience	Has knowledge, skills, and ability. Incident was accidental, inadvertent or oversight.	Limited understanding of correct procedure. May be novice < 6 months experience in nursing or with current event / activity.	Limited understanding of options / resources. Aware of correct procedure but in this instance cut corners. May be advanced beginner – 6 months to 2 years experience in nursing or with current event / activity.	Aware of correct action / rationale but failed to apply in this incident. Did not obtain sufficient information or utilize resources before acting. May be competent > 2 years experience in nursing or with current event / activity.	In this instance there was intentional negligence or failure to act / not act according to standards. Risk to client outweighed benefits. May be In a position to guide / influence others. May be proficient > 5 years in nursing or with current event / activity.	In this instance there was intentional gross negligence / unsafe action / inaction. Licensee demonstrated no regard for client safety and harm almost certainly would occur. May hold a leader / mentor position. May be expert performer > 5 years in nursing or with event / activity.	
I	Internal policies / standards / orders	Unintentional breach or no policy / standard / order exists.	Policy / standard / order has not been enforced as evidenced by cultural norm (common deviation of staff) or policy / standard / order was misinterpreted.	Policy / standard /order clear but nurse deviated in this instance as a time saver. Failed to identify potential risk for client. No evidence of pattern.	Aware of policy / standard / order but ignored or disregarded to achieve perceived expectations of management, client, or others. Failed to utilize resources appropriately. May indicate a pattern.	Intentionally disregarded policy / standard / order for own personal gain.	Intentional disregard of policy / standard / order with understanding of negative consequences for the client.	
D	Decision / choice	Accidental / mistake/ inadvertent error.	Emergent situation – quick response required to avoid client risk.	Non-emergent situation. Chose to act / not act because perceived advantage to client outweighed the risk.	Emergent or non-emergent situation. Chose to act / not to act without weighing options or utilizing resources. Used poor judgment.	Clearly a prudent nurse would not have taken same action. Unacceptable risk to client / agency / public. Intentional disregard for client safety.	Willful egregious / flagrant choice. Put own interest above that of client / agency / public. Intentionally neglected red flags. Substantial and unjustifiable risk.	
E	Ethics / credibility / accountability	Identified own error and self reported. Honest and remorseful.	Readily admitted to error and accepted responsibility when questioned. Identified opportunities and plan for improvement in own practice.	Reluctantly admitted to error but attributed to circumstances to justify action / inaction. Cooperative during investigation and demonstrated acceptance of performance improvement plan.	Denied responsibility until confronted with evidence. Blamed others or made excuses for action / inaction. Failed to see significance of error. Reluctantly accepted responsibility and denied need for corrective action.	Denied responsibility despite evidence. Indifferent to situation. Uncooperative, insubordinate and / or dishonest during investigation.	Took active steps to conceal error or failed to disclose known error. Provided misleading information during investigation or destroyed evidence. May have inappropriately confronted others regarding investigation.	

Criteria Score _____

updated 11.3.2020; updated 9.8.2021; updated 9.8.2022; updated 2.3.2023; updated 3.27.2024; updated 7.22.2024; 032025; 072025

North Carolina Board of Nursing (NCBON)
COMPLAINT EVALUATION TOOL (CET)

	Mitigating Factors -check all identified		Aggravating Factors - check all identified	
	Communication breakdown (multiple handoffs, change of shift, language barrier		Took advantage of leadership position	
	Limited or unavailable resources (inadequate supplies / equipment)		Especially heinous, cruel, and / or violent act	
	Interruptions / chaotic environment / emergencies – frequent interruptions / distractions		Knowingly created risk for more than one client	
	Worked in excess of 12 hours in 24 / or 60 hours in 40 to meet agency needs		Threatening / bullying behaviors	
	High Work volume / staffing issues		Disciplinary action (practice related issues) in previous 13 – 24 months	
	Policies / procedures unclear		Vulnerable client: geriatric, pediatric, mentally / physically challenged, sedated	
	Performance evaluations have been above average		Worked in excess of 12 hours in 24 / or 60 hours in 40 to meet personal needs	
	Insufficient orientation / training		Other (identify)	
	Client factors (combative / agitated, cognitively impaired, threatening)			
	Non-supportive environment – interdepartmental conflicts			
	Lack of response by other departments / providers			
	Other (identify)			
	Total # mitigating factors identified		Total # aggravating factors identified	

Criteria Score from page 1 _____

No Board Contact Required	A Report May Be Required. Board Consultation Suggested	Board Report Required
Contact with NCBON is not required if: ○ 3 or more criteria in green OR ○ Criteria score of 6 or less	Consult with NCBON if: ○ 3 or more criteria in yellow OR ○ Criteria score 7 – 15 Call: 984-238-7681 Email: practice@ncbon.com	Mandatory report to NCBON if: ○ 2 or more criteria in red OR ○ Criteria score 16 or more OR ○ Incident involves fraud, theft, drug abuse, diversion, sexual misconduct, mental / physical impairment. Go to website: (www.ncbon.com)

CET Completed by: _____ Facility Name: _____
Contact Number & Email address: _____
Date of Consultation with NCBON _____ NCBON Consultant: _____ Action Taken: _____

North Carolina Board of Nursing Complaint Evaluation Tool (CET) Directions for Use

The NCBON CET provides a framework through which nursing leaders can evaluate nursing clinical practice events. The NCBON Complaint Evaluation Tool (CET) is designed only for use in evaluating all clinical practice events or issues involving Registered Nurses and Licensed Practical Nurses, all of whom are regulated by the NCBON. Some facilities may have training and experience in the use of the "Just Culture" Algorithm developed by David Marx and The Just Culture Company, LLC. If this is the case, participants will first evaluate the event using the "Just Culture" Algorithm and will then use the NCBON CET to determine the reportability of the event to the Board.

It is important to note that confidentiality, fraud, theft, drug abuse, impairment on duty, drug diversion, boundary issues, sexual misconduct, and mental/physical impairment are not appropriate for evaluation using the CET. These events/issues are conduct and health-related issues, not practice incidents or events, and MUST be reported to the NC Board of Nursing.

NCBON Complaint Evaluation Tool (CET) Procedure:

When an untoward event (error, mistake, misunderstanding, or system failure resulting in actual or potential adverse outcome) occurs, the Chief Nurse Executive or nursing leader designee of the healthcare facility investigates the event and completes the NCBON CET. Use of the NCBON CET provides a standard by which the employer and Board can work collaboratively and communicate openly.

- CET results scored at the **Human Error** level (criteria score of 6 or less **OR** 3 or more criteria in Green column on CET) do not require Board contact.

  Remember that when human error is identified, the next step is to understand why the error occurred. The underlying causes can be addressed within the system to prevent reoccurrence.

- CET results scored at the **At-Risk Behavior** level (criteria score of 7 to 15 **OR** 3 or more criteria scored in Yellow columns on CET) **suggests a Board Consultation** for discussion and guidance in determining the appropriateness of facility-level remediation versus the need for filing a formal report or complaint. The Education and Practice Consultant, in partnership with the healthcare facility designee, reviews the event and utilizes the NCBON CET to guide analysis of the event and identification of appropriate actions/remedies.

The At-Risk Behavior collaborative review by the employer and Board Consultant may result in:

1. Consultation Only - Employer supports nurse and no further action is needed.
2. Employer Directed Corrective Action - Employer addresses incident with nurse through system intervention, internal disciplinary processes, and/or individual remediation.
3. Remedial Action - Board and Employer address incident through remediation agreement with licensee or through Board directed remediation/education.
4. Formal Reporting - Employer instructed to submit report/complaint to Board. Board then conducts inquiry and/or investigation according to established policies and processes.

- CET results scored at the **Reckless Behavior** level (criteria score of 16 or more **OR** 2 or more criteria scored in Red columns on CET) **require submission of formal Board report/complaint.**

North Carolina Board of Nursing Complaint Evaluation Tool (CET) Directions for Use

Anticipated Outcomes:

- Use of "Just Culture" principles and the NCBON Complaint Evaluation Tool (CET) provides the employer with the assurance that an adverse event has been handled appropriately from a regulatory perspective.
- "Just Culture" philosophy provides a framework for both the employer and Board to consistently apply expectations for accountability and behavioral choices, while treating individuals respectfully and fairly.
- Early collaboration with an NCBON Education and Practice Consultant facilitates timely resolution of the matter in a respectful way that promotes retention of valuable staff.
- Open communication in analyzing errors assists both the employer and Board in understanding underlying causes and provides valuable information that can be used to guide evidence-based practice.

Use of the NCBON Complaint Evaluation Tool (CET):

The NCBON CET is completed and scored as follows:

1. Every nursing clinical practice event is rated using the criteria identified in all 5 horizontal Rows of the CET - these criteria are summarized by the word GUIDE:

	Criteria
G	General Nursing Practice
U	Understanding/ level of experience
I	Internal policies/standards/orders
D	Decision/choice
E	Ethics/credibility /accountability

2. The 6 CET vertical Columns provide criteria descriptors indicative of Human Error (Green), At-Risk Behavior (Yellow), and Reckless Behavior (Red). Point values are designated at the top of each column.

Human Error	At-Risk Behavior			Reckless Behavior	
0	1	2	3	4	5

These point values are scored in the far-right column, totaled as a Criteria Score, and carried to the middle left side on page 2 of the CET. In addition, the total number of Green, Yellow, and Red criteria boxes scored is each noted for consideration on page 2.

North Carolina Board of Nursing Complaint Evaluation Tool (CET) Directions for Use

The Criteria Score evaluated on Page 1 of the CET may be overridden by the ranking of 3 or more criteria in either the Green or Yellow columns or by 2 or more criteria in the Red columns. For example, if an event was rated with 1 point in the At-Risk section in all 5 rows, and there were no mitigating or aggravating factors, the Criteria Score of 5 would normally be indicative of Human Error and no board contact would be required. However, with all 5 criteria being Yellow; this event clearly involved At-Risk Behavior and should, therefore, be evaluated and resolved in consultation with the Board of Nursing.

1. Mitigating Factors and Aggravating Factors that may influence the final Board decision regarding reportability are then noted in the boxes at the top of page 2. If present, the box next to the issue is checked by the person completing the form. Issues other than those already described in either section may be identified and inserted by the evaluator. These Mitigating and Aggravating Factors will be discussed and considered during consultation with the Education and Practice Consultant in determining the reportability of the event.

2. Once employers or nursing leaders have evaluated the nursing practice event using the CET, they follow the directives in the three boxes at the bottom of Page 2 of the CET:

No Board Contact Required	A Report May Be Required. Board Consultation Suggested	Board Report Required
Contact with NCBON is not required if: ○ 3 or more criteria in green OR ○ Criteria score of 6 or less	Consult with NCBON if: ○ 3 or more criteria in yellow OR ○ Criteria score 7 – 15 Call: 984-238-7681 Email: practice@ncbon.com	Mandatory report to NCBON if: ○ 2 or more criteria in red OR ○ Criteria score 16 or more OR ○ Incident involves fraud, theft, drug abuse, diversion, sexual misconduct, mental / physical impairment. Go to website: (www.ncbon.com)

- CET results scored at the **Human Error** level (criteria score of 6 or less **OR** 3 or more criteria in Green column on CET) do **not** require Board contact.

- CET results scored at the **At-Risk Behavior** level (criteria score of 7 to 15 **OR** 3 or more criteria scored in Yellow columns on CET) **suggests a Board Consultation** for discussion and guidance in determining the appropriateness of facility-level remediation versus the need for filing a formal report or complaint. The Education and Practice Consultant, in partnership with the healthcare facility designee, reviews the event and utilizes the NCBON CET to guide analysis of the event and identification of appropriate actions/remedies. **Final determination of reportability lies with the Board,** but the determination of alternatives for resolution of events determined to not require reporting are based on collaborative consideration.

- CET results scored at the **Reckless Behavior** level (criteria score of 16 or more **OR** 2 or more criteria scored in Red columns on CET) **require submission of formal Board report/complaint.**

North Carolina Board of Nursing Complaint Evaluation Tool (CET) Directions for Use

3. An NCBON Education and Practice Consultant can also be called at any time to obtain support and guidance in use of the CET. The event is discussed, and ambiguities are considered and resolved. The requirement for reporting and alternatives for resolution are discussed.

4. Employers should retain the CET in the file for each practice event investigated. Employers or nurse leaders are asked to attach a copy of the completed CET to the Board report/complaint when submission of a report/complaint is required or directed.

5. Feedback on the effectiveness and usefulness of the CET is welcomed and can be provided verbally or in writing to the Education and Practice Consultants.

Suggestions for Event Investigation

Why is event investigation important?

- Identify causes of event - both individual and system issues.
- Prevent similar occurrences.
- Reduce risks to clients and to the organization.

How should event investigation be done?

- Identify a logical, thorough method that works effectively within your setting.
- Approach investigation with an open mind - **avoid** pre-judging individuals or focusing only on the last person involved in the event!
- Consistently use the same method for evaluating all events.
- Consider **ALL** contributing factors - both individual and system.
- **Avoid** considering the extent of harm experienced by the client or others! - near misses are as important as actual harm - keep up your focus on behavioral choices and on risk. Don't fall into the "no harm - no foul" trap!
- **Don't** look for or accept the easy answer! - Keep asking **"WHY"** as many as 5 times in a row after each answer you receive in response to your questions! This will make it possible to identify and address the most significant, root causes of the issue as thoroughly as possible.

Model Investigation Method

Use the reliable How? When? Where? Who? What? and Why? questions in a consistent manner to assure that you have examined all elements of and influences on the event.

Answer and document all of the following questions concerning the event in question:

HOW was the event identified or discovered?

WHEN was the event identified or discovered?

- When did the event happen? - At what time?

WHERE did the event occur?

- Describe location and any unusual elements of the environment and location.

WHO has direct knowledge of the event?

- Who discovered or identified the event and how did they do so? - How did the event come to their attention?
- Who reported the event and how did they do so? - How did the event come to their attention?
- Who was directly involved in the event?
  - nurse(s)
  - physicians
  - other staff (e.g., nurse aides, therapists, secretaries)
  - client(s)
  - family members/visitors

Suggestions for Event Investigation

- How were each of the individuals involved in the event? What role did they play in the event?
- Interview nurse(s) and other involved staff (each separately) as soon as possible after the event:
    - Start by using open-ended questions and allowing involved staff to tell their stories about what happened;
    - What rationale did they offer for their behavioral choices?
    - What was their perception of risk?
    - Did they acknowledge and accept responsibility for event fully or partially?
    - Were they previously formally counseled (i.e., documented and signed) for same or similar issues?
    - Were they experienced and oriented to this unit, patient type, etc.?
- Interview witnesses (each separately) as soon as possible after event:
    - Start by using open-ended questions and allowing direct witnesses to tell their stories about what happened;
    - Consider degree of agreement or disagreement among witness statements;
    - Consider facts and what was actually observed by individuals - do not consider opinions not supported by evidence and corroborating statements.

WHAT happened?

- Describe the actual event in detail;
- Reconstruct the sequence of events;
- Remember to consider preceding activities that may have impacted the event.

- What usually happens in similar situations? - Describe what involved staff and non-involved staff tell you about such situations - what is their “normal”, current practice? (Make sure they are not just telling you what you want to hear or what policy says!)
- What should have happened? - describe related policies and procedures. (When actual practice varies from policy, you will want to explore why and address this with all staff- maybe policy is out of date or impossible to follow - or maybe all staff have drifted from safe practice!)

WHY did the event occur?

- Identify any and all factors contributing to the event.
- What behavioral choices related to the event did each involved nurse or individual make before, during, and following the event?
- What behavioral choices would a similarly prepared and experienced prudent nurse (or other involved person) have made in the same situation?
- If individual(s) deviated from standards, policies, or procedures, identify rationale for decision to deviate.
- What was happening with other clients and in the environment at the time of the event and immediately prior to the time of the event?
- What was the nurse to client ratio at the time of the event? - Was this a safe, acceptable, manageable ratio?

Suggestions for Event Investigation

- Describe any variable factors, such as busy unit, staff call-outs, etc., that influenced
- workload at the time of the event.
- Was this the usual assignment/unit for the nurse(s) involved in the event?
- What equipment/supplies were involved in the event? - describe equipment/supplies and any unusual aspects, malfunctions, availability issues, etc.

COLLECT AND PROTECT all physical evidence:

- Documentation and records;
- Audit current and past records, if indicted, to identify documentation discrepancies, deficits, and omissions;
- Supplies, equipment, medications, etc.

SUMMARIZE AND DOCUMENT investigation results and conclusions:

- Identify all system issues that need to be corrected.
- Identify all individual practice issues that need to be addressed.
- Identify all known contributing/mitigating/aggravating factors - system and individual.

For nurses' practice issues, the next step is to complete the NCBON Complaint Evaluation Tool (CET). The NCBON CET is designed for use in evaluating clinical practice events or issues involving Registered Nurses and Licensed Practical Nurses, all of whom are regulated by the NCBON. North Carolina is a "mandatory" reporting state, meaning that any suspected violations of the Nursing Practice Act must be reported to the Board. The NCBON CET provides a "Just Culture" framework through which nursing leaders/employers can evaluate nursing clinical practice events. Use of the NCBON CET provides a standard by which the employer and Board can work collaboratively and communicate openly. The CET directs nursing leaders/employers to console nurses for Human Errors; to consult with Board staff to determine the reportability of At-Risk Behaviors; and to submit a formal report/complaint to the Board for Reckless Behaviors.

Some organizations may have training and experience in the use of the "Just Culture" Algorithm developed by David Marx and Outcome Engenuity. If this is the case, participants will first evaluate the event using the "Just Culture" Algorithm and will then use the NCBON CET to determine the reportability of the event to the Board.

NOTE: Confidentiality, fraud, theft, drug abuse, impairment on duty, drug diversion, boundary issues, sexual misconduct, and mental/physical impairment are <u>not</u> appropriate for evaluation using the NCBON CET. These events/issues are conduct and health-related issues, not practice incidents or events, and MUST be reported to the NC Board of Nursing.

Resources and Contact Information

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