“Just Culture”
in
Nursing Education Programs

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“Just Culture” Program Toolbox

NURSING EDUCATION PROGRAMS

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Just Culture
Talking Points

- "Just Culture" - a term coined by David Marx, an engineer and attorney, who 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 individuals 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 generally have control of our behavioral choices.

The principle behind a "Just Culture" is this: Discipline needs to be tied to the behavior of individuals and the potential risks their behavior presents more than the actual outcome of their actions. A "Just Culture":

- Places focus on evaluating the behavior, not the outcome;
- Requires leadership commitment and modeling;
- Distinguishes between normal error, unintentional risk-taking behavior and intentional risk-taking behaviors;
- Fosters a learning environment that encourages reporting of all mistakes, errors, adverse events, and system weaknesses (including self-reports);
- Lends itself to continuous improvement of work processes and systems to ensure the highest level of patient 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 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 individual, not merely 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 patient 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 choice of the individual, the degree of risk-taking, and whether the individual deliberately disregarded a substantial risk. It holds the individual accountable who makes unsafe or reckless choices that endanger patients.

“Just Culture” has been introduced in many healthcare organizations and in several states having statewide patient safety initiatives. Many settings use an Algorithm developed by David Marx for evaluating events and determining whether the actions of the individual warrant consoling, coaching, counseling, remediation, or punishment. The NC Board of Nursing is supportive of a “Just Culture” approach to patient safety and individual accountability.

- ”Just Culture” provides a mechanism for nurse employers, educators, and regulators to come together to promote a culture that promotes learning from practice errors while properly assigning accountability for behaviors, consistently evaluating events, and complying with mandatory reporting requirements for licensed nurses.

- The NC Board of Nursing is committed to working with Nursing Education Programs interested in using “Just Culture” principles in addressing practice events occurring with students in their clinical practice settings.

- “Just Culture” in Nursing Programs uses a Student Practice Event Evaluation Tool (SPEET) developed by the NCBON for evaluating practice events and determining whether the actions of the individual student warrant consoling, coaching, counseling, remediation, or disciplinary action. This tool can be used by program directors and faculty, in collaboration with board consultants as needed, to evaluate student practice events with consistency and fairness, while providing the opportunity to learn from mistakes and enhance patient safety.

Overview of "Just Culture" Project

Background:

Since 2007, the North Carolina Board of Nursing (NCBON) has partnered with the NC Center for Hospital Quality and Patient Safety's "Just Culture" collaboratives, hospitals, long term care skilled nursing facilities, and nursing education programs in promoting the evaluation, and resolution of adverse events in a positive manner. The purpose of these pilot projects was to provide a mechanism for nurse employers educators, and regulators to come together to promote a culture that promotes learning from practice errors while properly assigning accountability for behaviors, consistently evaluating events, and complying with mandatory reporting requirements for licensed nurses.

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. In recent years, NCBON has made concerted efforts to move away from a culture of blame and shame and toward a culture of quality improvement with an emphasis on patient safety. In 2001, NCBON began the Practitioner Remediation and Enhancement Partnership (PREP) Program, where minor practice violations could be addressed in a positive, non-disciplinary manner. The PREP Program encourages employers to contact NCBON staff, consult about issues, and when indicated, work in collaboration to develop a plan for remediation. PREP opened lines of communication and demonstrated that NCBON could be a valuable partner in early interventions to promote safe practice BEFORE the need for disciplinary action occurs.

As a natural outgrowth of the PREP philosophy and consistent with our strategic plan, the NCBON adopted a "Just Culture" philosophy. As employers of nurses and NCBON staff discuss adverse events, they jointly utilize the NCBON 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 "Just Culture" philosophy and the NCBON Complaint Evaluation Tool serve as the basis for all decisions in these pilot projects. It is our hope that lessons learned can be generalized and spread throughout North Carolina.

North Carolina Nursing Education Programs:

The NCBON then invited NC Nursing Education Programs to participate in a pilot project to encourage use of the "Just Culture" philosophy and principles in evaluating student practice events that occur in clinical practice settings. Fair and consistent management of these adverse events is challenging for nursing program directors and faculty. Participating programs used a new board-developed Student Practice Event Evaluation Tool (SPEET). Schools, however, retained full control of all decisions regarding interventions with students as determined appropriate in resolution of practice events.

North Carolina Board of Nursing
NURSING EDUCATION "JUST CULTURE" PROGRAM

Student Practice Enhancement

Purpose: The purpose of the "Just Culture" program is to provide a mechanism for Nursing Education Program faculty and the regulatory board to come together to develop a culture that promotes learning from student practice errors while properly assigning accountability for behaviors and consistently evaluating events.

Background: 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 have been told that as many as 180,000 deaths occur in the United States each year due to errors in health care. It is inevitable that individuals, including nursing students, make mistakes in today's complex and interdependent health care environment. Most errors take place within complex systems; however, when errors occur, the immediate solution is 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 have to provide a forum where errors or unanticipated outcomes can be used as the basis for a learning process, rather than grounds for punishment. This program proposes to provide that forum where the "Just Culture" philosophy and principles and an NCBON Student Practice Event Evaluation Tool (SPEET) can guide program directors and faculty in review of practice errors or clinical performance deficiencies, in partnership with the Board as indicated, focusing on resolutions that promote student practice enhancement and patient safety.

References:

Institute of Medicine. (2000). *To err is human: Building a safer* h*ealth 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).

Procedure: When an untoward event (error, mistake, misunderstanding or system failure resulting in harm, potential harm, near miss, or adverse outcome) occurs, the Nursing Program Director and Faculty apply the "Just Culture" philosophy and principles and complete the NCBON Student Practice Event Evaluation Tool (SPEET). If needed, an Education Consultant may be contacted and, in partnership with the Program Director and faculty, will review the event. The "Just Culture" principles and the NCBON SPEET will guide analysis of the incident and identification of appropriate remedies. Use of the "Just Culture" principles and the NCBON SPEET will provide a standard by which the Program Director, Faculty, and Board consultant can work collaboratively and

communicate openly. The Nursing Education Program retains full control over interventions with students determined necessary in resolving the event in accordance with Institutional policies and procedures.

The "Just Culture" review may result in the following recommendations:

1. Human Error – Program Director and Faculty will support and console the student. If indicated, a remedial improvement plan may be developed with the student.

2. At-Risk Behavior – Program Director and Faculty will coach student and possibly counsel. Remedial improvement plan will be developed with student, as indicated.

3. Reckless Behavior – Program Director and Faculty will consider disciplinary action and/or remedial action in addressing event with student. Disciplinary action will adhere to Program and Educational Institution policies and directives.

4. System Issues Contributing to Event – Program Director and Faculty will address school-related system issues through established processes. Program Director and Faculty will address clinical setting system issues with appropriate agency management and administrative staff. Student involvement in resolution of system issues will be encouraged as learning opportunity.

Proposed Outcomes:

"Just Culture" approach provides the Nursing Program Director and Faculty with the assurance that adverse student practice events are resolved appropriately, fairly, and consistently.

"Just Culture" philosophy provides a framework for the Nursing Program Director and Faculty to consistently apply expectations for accountability and behavioral choices, while treating individuals respectfully and fairly.

Collaboration with Education Consultant, if indicated, facilitates timely resolution of the matter in a respectful way that promotes both patient safety and appropriate retention of students.

Open communication in analyzing student practice events will assist both the Program and Board in understanding underlying causes and provide valuable information that can be used to guide evidence-based practice.

Guidelines For Using SPEET & Consulting with the Board of Nursing

In fulfilling its mission to safeguard the public health, safety, and welfare, the Board is committed to nursing practice and 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 nursing students who are involved in practice events in a clinical setting. This is particularly true when there are mechanisms in place to identify nursing events, detect patterns of practice, take corrective action, and monitor the effectiveness of remediation on deficits in a student nurse's behavior and practice including judgment, knowledge, training, or skill. A Just Culture approach can be used rather than viewing dismissal from the program as the primary option.

The NCBON Student Practice Event Evaluation Tool (SPEET) provides a framework through which Program Director and Faculty can evaluate student clinical practice events as follows:

1. Every student clinical practice event is rated in all 5 rows of the tool - summarized by the word **GUIDE**:

General nursing practice;
Understanding expected based on program level, course objectives/outcomes;
Internal policies/standards/interdisciplinary orders;
Decision/choice; and
Ethics/credibility/accountability.

2. The Columns provide criteria descriptors indicative of Human Error (Green), At-Risk Behavior (Yellow), and Reckless (Red) Behavior. Point values are assigned at the top of each column. These point values are scored in the far right column and carried to the top of the White box in the middle left side on page 2 of the SPEET. In addition, the total number of Green, Yellow, and Red criteria are each noted in the Green/Yellow/Red boxes in the middle right side on page 2.

3. Mitigating Factors and Aggravating Factors in the Green and Red boxes at the top of page 2 are then considered. If present, the appropriate points are deducted and/or added to the Criteria Score carried from page 1 to obtain Total Overall Score in the White box in the middle left side of page 2. This Total is an indicator of Human Error, At-Risk, or Reckless Behavior as noted in the Green/Yellow/Red boxes in the middle right side of page 2. This Total Score may be overridden by the number of criteria in a single color. (For example, if an event was rated with 1 point in At-Risk section in all 5 rows, and there were no mitigating or aggravating factors, the Total Overall Score of 5 would be indicative of Human Error BUT with all 5 criteria being Yellow; this event clearly involved At-Risk Behavior and should be resolved as such.)

4. Once Program Director and Faculty have evaluated the student practice event using the SPEET, a call may be made to one of the NCBON Education Consultants to obtain support and guidance in use of the tool if needed. The event will be discussed and ambiguities will be considered. Alternatives for resolution will be discussed. Final determination of resolution lies with the Program and is in accordance with Educational Institution Policies.

5. A copy of the completed SPEET should be retained in the student's file.

Guidelines For Using SPEET & Consulting with the Board of Nursing

NOTE: See examples of Human Error, At-Risk Behavior, Reckless Behavior, and Systems Issues on below.

Human Error

Definition: Student inadvertently did something other than intended or other than what should have been done; a slip, lapse, an honest mistake.

Criteria: Refer to the NCBON Student Practice Event Evaluation Tool (SPEET) – Human Error Section/Green Column. Each item chosen in this column is valued at 0 points.

Examples of Human Error Student Practice Events:

- One time medication error (wrong dose, wrong route, wrong patient, wrong time)
- Failure to implement a treatment order due to oversight

At Risk Behavior

Definition: Student makes a behavioral choice that increases risk where risk is not recognized or is mistakenly believed to be justified; student does not appreciate risk; unintentional risk taking. Generally the student's performance does not indicate that his/her continuing practice poses a risk of harm to the client or other person.

Criteria: Refer to the NCBON SPEET – At Risk Behavior Section/Three Yellow Columns. Each item chosen in these columns is valued at 1, 2, or 3 points.

Examples of At Risk Behavior:

- Exceeding scope of practice for which the student is being educated
- Pre-documentation
- Minor deviations from established procedure

Reckless Behavior

Definition: Student makes the behavioral choice to consciously disregard a substantial and unjustifiable risk.

Criteria: Refer to the NCBON SPEET – Reckless Behavior Section/Two Red Columns. Each item chosen in these columns is valued at either 4 or 5 points.

Examples of Reckless Behavior:

- Leaving shift before completing all assigned care because student has a date waiting
- Student observed patient starting to climb over bedrails and did not intervene
- Student made medication error, realized it, told no one, and falsified the MAR to conceal error

NOTE: Academic cheating, inappropriate use of social media, confidentiality, fraud, theft,

drug abuse, impairment, drug diversion, boundary issues, sexual misconduct, and mental/physical impairment are not appropriate for evaluation with the SPEET – these are conduct and health-related issues, not practice events.

Systems Issues

Definition: Events or event elements that are primarily the result of factors beyond the student'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. Opportunities for system improvements may exist independent of, or in conjunction with, opportunities for individual improvement.

Examples of Systems Issues:

- Malfunctioning equipment
- Interdepartmental delays

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