

# IMPROVING NURSING REGULATION

## The “Just Culture” Approach

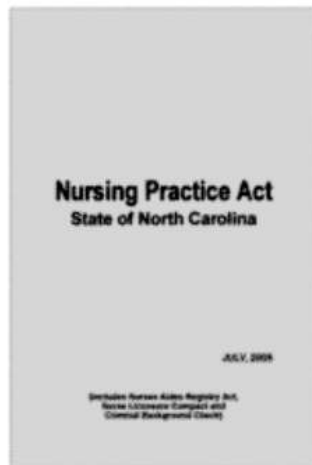
---

Linda D. Burhans, RN, PhD  
Associate Executive Director, Education and Practice



May 2010

# Mandate from General Assembly (Nursing Practice Act)



**Licensure of all who engage in the practice of nursing is necessary to ensure minimum standards of competency and provide the public safe care**



# Board Composition

The Board of Nursing is comprised of 14 members:

- ❑ 8 Registered Nurses
- ❑ 3 Licensed Practical Nurses
- ❑ 3 Public Members



Nancy Bruton-Maree



Beverly Davis



Pamela Edwards  
Board Chair



Beverly Essick



Mary Ann Fuchs



Joan Giulianelli



Sara Griffith



Martha Ann Harrell



Daniel Hudgins



Cynthia Morgan



Robert Newsom



Deborah Jenkins  
Board Vice-Chair



Holly Rabinovich



Alexis Welch

# North Carolina Board of Nursing Mission Statement

---

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



**January 2010**



# North Carolina Board of Nursing Vision Statement

---

**The NCBON proactively advances public protection and regulatory excellence through:**

- (1) leadership in addressing challenges in a dynamic healthcare environment; and**
- (2) innovation that drives continuous process improvement.**



# North Carolina Board of Nursing Just Culture and Nursing Regulation

---

## OBJECTIVES

- Describe the evolution of the Board's approach to remediation for practice related issues.
- Discuss the Board's Just Culture pilot projects.



# North Carolina Board of Nursing Just Culture and Nursing Regulation

---

## Evolutionary Timeline

- 1999 – Discipline Review Task Force convened
- 2000 – Invited by CAC to participate in PREP
- 2001 – Implemented PREP Pilot
- 2001 – Began with 8 hospitals
- 2002 – Expanded to nursing homes
- 2004 – Expanded to statewide program



# PREP

## Practitioner Remediation and Enhancement Partnership

---

- Purpose is to enhance quality of care through increasing cooperation and collaboration between providers and regulators
- Shifts focus away from “blame” and toward improving practice and learning from errors
- Non-public, non-disciplinary agreements for practice improvement



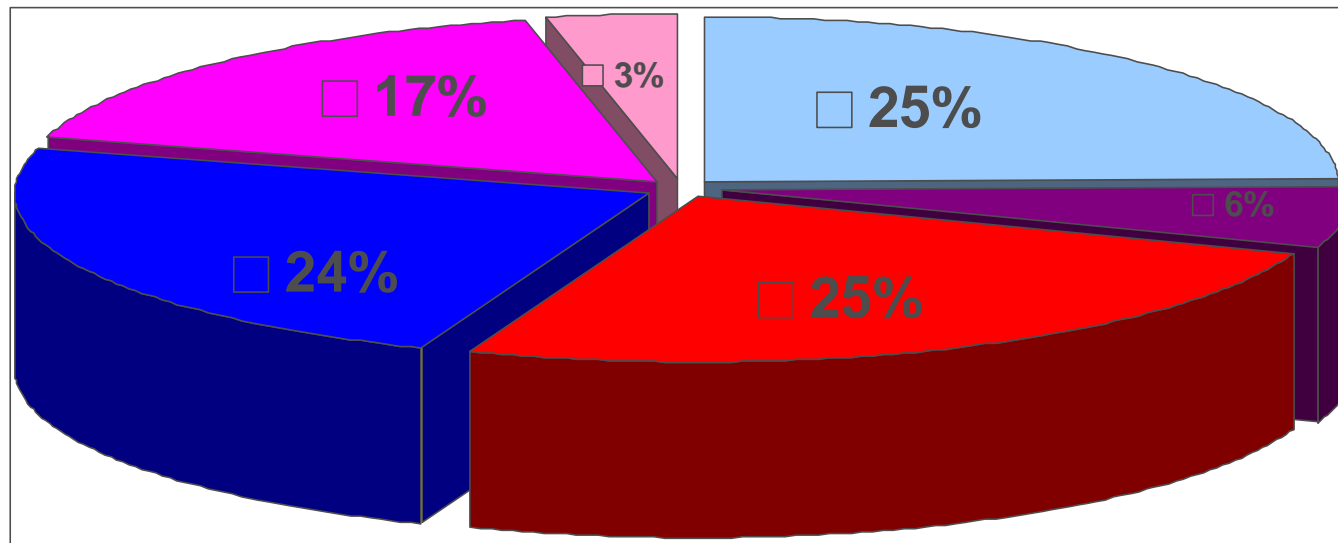
# Essential PREP Elements

---

**Voluntary, non-public, non-punitive**

- **Collaborative approach**
- **Motivation to enhance competence**
- **Opportunity to learn from mistakes**
- **NOT a substitute for disciplinary action**

# 2009 PREP Cases – N=129



■ Exceed scope   ■ Patient Rights   ■ Competency  
■ Patient Care   ■ Documentation   ■ Other

# Timeline — Just Culture and Nursing Regulation

---

- 2003 – “Minor Incident” project began
- 2004 – Began use of non-published consent agreements
- 2005 – Practice consultants began review of ALL practice complaints



# Timeline — Just Culture and Nursing Regulation

---

- 2005 – David Marx introduced “Just Culture” to NC BON staff/guests
- 2006 – Supported NCCHQPS Just Culture Collaborative
- 2007– Expanded PREP to Just Culture focus



# Traditional Regulatory Model

---

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

# Why Just Culture matters ...

---

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

# Just Culture

---

- ... promotes patient safety and quality improvement, because it moves us to a model that examines behavioral choices, NOT outcomes of events
- ... balances individual accountability with system accountability
- ... promotes learning from errors

# **North Carolina Board of Nursing Just Culture and Nursing Regulation**

---

## **NCBON Just Culture Focus:**

- **encourage Just Culture models**
- **increase collaboration with and support for employers implementing Just Culture**
- **pilot new NCBON Complaint Evaluation Tool with selected employers**
- **employers and regulatory board evaluate practice issues with consistency and fairness**



# North Carolina Board of Nursing Just Culture and Nursing Regulation

---

## NCBON Pilot Project:

- Consistent with Board Strategic Initiative to promote Just Culture model for accountability
- Differentiates incidents resulting from human error from those resulting from at-risk and reckless behaviors
- Utilizes collaborative approach to develop plan of remediation or determine need for discipline



# Just Culture Pilot Project Objectives

---

- ❖ Improve quality of nursing practice through focus on quality improvement versus discipline for errors
- ❖ Promote open communication and learning from individual and system failures
- ❖ Assure employers that NCBON mandatory reporting requirements have been met
- ❖ Facilitate employer remediation for minor incidents



# North Carolina Board of Nursing Just Culture and Nursing Regulation

**Pilot Project assists employers by:**

- 1) clarifying “reportable” incidents**
- 2) providing objective tool for evaluating reportability of incidents**
- 3) promoting evaluation focused on behavioral choices or level of risk, versus outcome**
- 4) using Just Culture algorithm and NCBON Complaint Evaluation Tool in consultation for consistency in resolution**



# **North Carolina Board of Nursing Just Culture and Nursing Regulation**

---

## **Pilot Project:**

- **Assures employers that mandatory reporting requirements have been met**
- **Facilitates retention of nurses whenever possible**
- **Allows option of employer-directed remediation of the nurse for event resolution as indicated**



# Just Culture Pilot Project Implementation

---

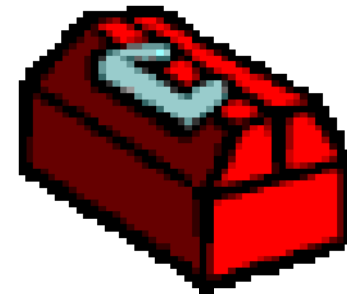
- Nurse leaders provided with a “tool kit” and educated on use of the NCBON Complaint Evaluation Tool (CET) using case scenarios
- Participants use the CET – subsequent to use of the Just Culture Algorithm – to assess all deviations in nursing practice and determine if report to Board is indicated
- Participants are encouraged to consult with Board staff as needed and to submit all completed tools
- Participants are encouraged to provide ongoing feedback and suggestions for tool improvement

# “Just Culture” Pilot Project Toolbox

---

## ■ Guidelines for Reporting Practice Violations to the Board

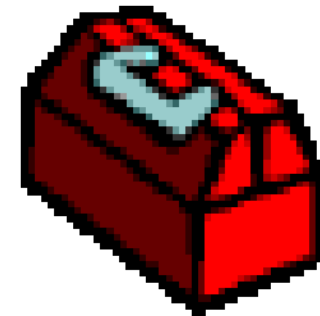
- non-reportable incidents
- systems issues
- human error
- at-risk behavior
- reckless behavior



# “Just Culture” Pilot Project Toolbox

---

- **Board of Nursing CET -  
Complaint Evaluation Tool**
  - scoring
  - mitigating factors
  - aggravating factors
  - documentation and  
submission



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

Allegation(s):		Licensee Name:					Score
Criteria	Human Error	At Risk Behavior			Reckless Behavior		
	0	1	2	3	4	5	
G	General Nursing Practice	No prior counseling for practice related issues	Prior counseling for single non-related practice issue within last 12 months	Prior counseling for single related issue within past 12 months	Prior counseling for same issue within last 12 months	Prior counseling for various practice issues within the last 12 months	Prior counseling for same or related issue within last 6 months with minimal to no evidence of improvement.
U	Understanding/ level of experience	Has knowledge, skill and ability. Incident was accidental, inadvertent, or oversight	Novice < 6 months experience in Nursing or with current event/activity. Limited understanding of correct procedure.	Advanced beginner - 6 months to 2 years experience in Nursing or with current event/activity. Limited understanding of options/resources. Aware of correct procedure but in this instance cut corners	Competent > 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.	Proficient > 5 years in Nursing or with current event/activity. In a position to guide/influence others. In this instance there was negligence or failure to act according to standards. Risk to client outweighed benefits.	Expert performer > 5 years Nursing or with event/activity. Leader/mentor position. In this instance there was gross negligence/ unsafe action and licensee demonstrated no regard for patient safety.
I	Internal policies/standards/ orders	Unintentional breach or no policy/standard exists.	Policy/order has not been enforced as evidenced by cultural norm (common deviation of staff) or policy/order was misinterpreted	Policy/order clear but nurse deviated in this instance as a time saver. Failed to identify potential risk for patient. No evidence of pattern.	Aware of policy/standard/order but ignored or disregarded to achieve perceived expectations of management, patient or others. Failed to utilize resources appropriately. May indicate pattern.	Disregarded policy/standard/order for own personal gain.	Intentional disregard of policy/standard/order with understanding of negative consequence for patient
D	Decision/choice	Accidental/mistake/ Inadvertent error	Emergent situation - quick response required to avoid patient risk	Non-emergent situation. Chose to act/not to act because perceived advantage to patient 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 patient/agency/public Disregard for patient safety.	Willful egregious choice. Put own interest above that of patient/agency/public. 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. May have inappropriately confronted others regarding investigation

Criteria Score \_\_\_\_\_

North Carolina Board of Nursing (NCBON)  
COMPLAINT EVALUATION TOOL

MITIGATING FACTORS	AGGRAVATING FACTORS
Communication breakdown (multiple handoffs, change of shift, language barriers)	Took advantage of leadership position
Limited or Unavailable resources (inadequate supplies/equipment)	Especially heinous, cruel, and/or violent act
Interruptions/Chaotic environment/emergencies- freq. 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	Other (identify)
Insufficient orientation/training	Total # aggravating factors
Client factors (combative/agitated, cognitively impaired, threatening)	
Non-supportive environment - interdepartmental conflicts	
Lack of response by other departments/providers	
Other (identify)	
<b>Total # mitigating factors identified</b>	

CRITERIA SCORE (from front page)	
Mitigating factors (subtract 1 point for 1-4 factors; 2 points for 5 - 8 factors; and 3 points for 9-12 factors)	
Aggravating factors (add 1 point for each identified factor)	
<b>Total Overall Score</b>	

HUMAN ERROR	AT RISK BEHAVIOR	RECKLESS BEHAVIOR
# criteria in green=  Report to NCBON is not required if: 3 criteria in green or total score <9	# criteria in yellow=  Consult with NCBON if: 3 criteria in yellow - or total score 10-19	#criteria in red=  Mandatory report to NCBON if: 3 criteria in red or total score 20+ or incident involves: fraud, theft, drug abuse, diversion, sexual misconduct, mental/physical impairment.

Evaluator: \_\_\_\_\_

Facility Name: \_\_\_\_\_

Date of Incident: \_\_\_\_\_

NCBON Consultant: _____
Action Taken: _____

# North Carolina Board of Nursing Just Culture and Nursing Regulation

---

## Collaborative review options:

1. ***Consultation Only*** – Employer will support and counsel employee
2. ***Employer-Directed Corrective Action*** – Employer to address through system intervention, internal disciplinary processes, and/or individual remediation
3. ***Corrective Action*** – Board and employer to address through remediation agreement with licensee (PREP)
4. ***Formal Reporting*** – Employer instructed to submit report/complaint to Board



# Desired Outcomes of Pilot Project

---

- **Develop a common framework for review of practice issues that lends itself to continuous quality improvement**
- **Balance non-punitive learning with individual and system accountability**
- **Enhance patient safety by providing safeguards in the event a licensee fails to complete remediation**



# Current Journey.....

## PHASES I and II

- 5 Hospitals
- 18 months (July 2007 through December 2008)
- 5 Additional Hospitals
- 18 months (January 2009 through June 2010)
- Determine reportability of practice events
- Gain experience in applying Just Culture Algorithm and NCBON Complaint Evaluation Tool
- Determine what works and what doesn't work



# Just Culture Pilot Project Initial Results

---

- 40 reports
- CET scores ranged from 1 – 23  
(on scale of 0 – 28)
- Employer resolutions for 17 cases – included no action, consoling, counseling, remediation, warning, suspension, and termination
- PREP referral indicated for 2 cases
- Formal report to Board indicated for 21 cases



# Just Culture Pilot Project Results

---

- **Complaints evaluated have included:**
  - ✓ **neglect**
  - ✓ **medication errors**
  - ✓ **exceeded scope of practice**
  - ✓ **falsification of medical records**
  - ✓ **failure to maintain accurate medical records**
  - ✓ **failure to follow protocols**
  - ✓ **breech of confidentiality**

# Current Journey.....

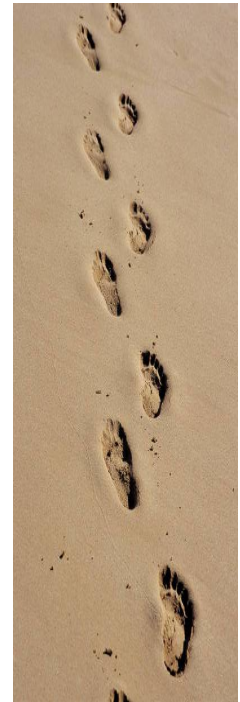
---

## PHASE III

- 10 Nursing Education Programs using participant hospitals as clinical sites
- 18 months (July 2010 through December 2011)
- promote balanced non-punitive approaches
- educate faculty and students about Just Culture principles and approaches

## PHASE IV

- 5 Long Term Care/Skilled Nursing Facilities
- 24 months (January 2010 through December 2011)



# Next Steps. . . . .

---

- **expand to include other regulatory bodies and other practice settings**
- **promote balanced, non-punitive approaches within diverse practice settings**



# Questions....

---



# Resources

---

**Contacts:**

**Telephone: (919) 782-3211**

- **Linda Burhans, RN, PhD**

**[Lburhans@ncbon.com](mailto:Lburhans@ncbon.com)**

**ext 265**

- **Pam Trantham**

**[Pamela@ncbon.com](mailto:Pamela@ncbon.com)**

**ext 279**

