



## NEWS and VIEWS

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### Interview with Julie George, RN, MSN Associate Executive Director-Programs North Carolina Board of Nursing



**M**s. George has been a registered nurse for more than 30 years and has been involved in nursing regulation since 1996 when she was employed with the North Carolina Board of Nursing as an Investigator.

In 2001, Ms. George became involved in efforts to re-frame how the NC Board of Nursing addressed practice errors and discipline. She was instrumental in developing policies and programs that focused on patient safety and quality improvement. North Carolina was the first Board of Nursing to partner with Citizen Advocacy Center and implement the Practitioner Remediation and Enhancement Partnership (PREP), a non-punitive, early intervention program for nurses.

She has been actively involved in the work of the National Council of State Boards of Nursing and has championed integrating Just Culture into regulator's day-to-day practices. The following interview describes Julie George's and the Board's pioneering work implementing Just Culture in a regulatory environment, in concert with the North Carolina provider community.

#### **Julie, can you tell us a little bit about your role in the Board of Nursing and how your and the Board's views have evolved?**

I'm the Associate Executive Director for Programs at the North Carolina Board of Nursing, overseeing practice and education, including the Complaint Department, investigations and disciplinary proceedings. After the 1999 Institute of Medicine (IOM) report, our Board consciously began efforts to change our culture from "blame and shame" to a culture of quality improvement and remediation. As a licensing Board, our primary purpose is regulation and protection

of the public, so our foremost responsibility is to recognize an unsafe practitioner and remove them from practice and from risk to the public.

Twelve years ago, we didn't have many options for resolution of practice errors. So when nurses violated the Practice Act, we made decisions based on outcomes. As a result, the same error might result in a different outcome for the nurse based on the outcome of the event. I always remember one nurse, this was early on in my career, who had been an excellent practitioner, with a long, 20-year-plus history of just impeccable practice, but

#### Contributors:

Scott Griffith, MS  
Chief Operating Officer

Sharon Comden, Dr. PH,  
Healthcare Consultant

## Interview with Julie George (continued)

she made an error while administering blood products. Looking back, there were some systems issues as well, but she committed a human error. There was no pattern of substandard practice and her behavior was not intentional or reckless. Immediately she recognized the error, but there was some transient harm. Because there was harm and it was a sentinel event, the nurse was reported to our Board. The usual sanction for such an incident at that time was that the Board issue a letter of reprimand, which may seem minor in nature to those who aren't nurses. It's a disciplinary action that's reported to the national practitioner data bank. The hospital terminated this otherwise outstanding nurse after 20 years of employment and she never returned to nursing. Everyone lost in this case because punishing a human error doesn't make healthcare safer. The community lost a fine nurse and this individual's career and self-confidence was shattered. Today, if that hospital had been using a Just Culture decision-making model, they would have consoled her; they wouldn't have terminated her.

### **How did you first learn about Just Culture concepts?**

I was at a patient safety conference in 2001 and heard Jim Battles mention David Marx' white paper- *Patient Safety and the "Just Culture": A Primer for Healthcare Executives*. When I read his paper the first time, it resonated with me so much because it's the right way to look at these kinds of events. The Primer started it for me, and I still refer people to it because it introduces the principles of Just Culture in such a clear and practical way that you realize how relevant it is to health care.

### **Why is the Board of Nursing using Just Culture principles to guide its strategic objectives?**

It enhances our ability to protect the public. Just Culture allows us to concentrate investigative and disciplinary resources to aggressively intervene with incompetent or unsafe practitioners rather than drilling down to punish someone for an isolated error. It complements our PREP program and helps us to focus public protection on incompetent practitioners, focus on quality improvement for those practitioners making errors, balance system and individual

accountability for patient safety, and finally, to base actions on behavioral choices/level of risk, NOT on the outcome of an incident.

Working closely with employers, who have responsibility for systems integrity, we're able to balance system and individual accountability, creating a forum for open dialogue where we all can learn and get at the root of what's going on.

For example, I recall a medication error involving a Pyxis machine; you hear of these quite often. There's an emergency going on, a nurse from another floor goes to the Pyxis machine, she opens the drawer, the medication she's looking for is similarly packaged, it's in the same bin as it would be on her home unit, she

grabs the medication—and it's the wrong medicine.

When we began talking about it with the hospital managers, they recognized that this error was an opportunity for them to

improve and to standardize Pyxis contents throughout the facility to reduce the risk of reoccurrence. And they involved this nurse in reviewing and revising the policy, even helping teach during the rollout of the new policy. The nurse became a partner in looking at what happened and coming up with a plan for improvement and impacting the whole system. This is a vastly different and more constructive outcome for all concerned than would have happened in the past.

### **What kinds of issues come up as you and your partners, individual hospital, systems, the state hospital association, and its North Carolina Center for Healthcare Quality and Patient Safety, move forward with your Just Culture initiatives?**

I think the toughest barrier, especially from a regulatory agency, is to overcome the tendency to be biased by the outcome of the error. It's human nature to look at the severity of an outcome. I think once you believe Just Culture is the right thing to do, you must recognize that there will be times when family members may want someone fired or want them to lose their license. It is difficult to explain that firing someone for a human error will not help protect the public. Our Board has grappled with those kinds of decisions and they are difficult, to be sure, but it's the right thing to do in the long run, for everyone.

**“The Primer started it for me, and I still refer people to it because it introduces the principles of Just Culture in such a clear and practical way that you realize how relevant it is to health care.”**

## Interview with Julie George (continued)

**The North Carolina Hospital Association has been very actively supporting statewide Just Culture initiatives. How is this impacting your reporting program?**

The Board of Nursing is starting a pilot program to explore how the Board and hospitals interface in a Just Culture. We have six hospitals working with our practice consultants. Because we're a mandatory reporting state, hospitals using Just Culture want to ensure that they are appropriately meeting the requirements for reporting incidents to the Board. So we developed a scoring tool aligned with the Just Culture algorithm that helps hospitals look at an event to see what level of reporting is necessary, i.e., is it something that can be handled adequately at the facility level? If there's an incident of "at risk" behavior that would benefit from consultation, a plan of action or remediation can be developed so we can address the matter through a non-disciplinary avenue such as our PREP program. The third level involves situations when intentional or very reckless behavior is involved, which should be reported immediately. An example would be a nurse in a hurry who knowingly falsifies a patient record that she delivered clinically important care when she didn't deliver the care, didn't do anything to correct or report the matter, and the patient was put in harm's way. The nurse chose an unsafe act, failed to correct her action, and then knowingly falsified the medical record. Working directly with our practice consultants helps the agency fast-track that type of report to the Board.

This type of Board/hospital collaboration helps both of us. The hospital is assured they've met reporting requirements, we both agree on the appropriate response to the error, and it can often be addressed through consultation rather than an official report. This is a project we've undertaken as part of our work with the National Council of State Boards of Nursing's Institute for Regulatory Excellence and our hope is that we can continue to evaluate and refine our reporting tool, and sometime in the future, it could be shared with other regulatory boards.

**As you reflect on the discussions you've had with people new to Just Culture, what is the most common concern that is brought up?**

The primary concern is the question: Will this somehow

compromise individual accountability; are you talking about a blameless approach? You have to be very clear about the types of things that are excluded, i.e., this is not a blameless approach, it doesn't take accountability away for intentional acts, the fraudulent or deceptive practitioner, the dishonest person, the nurse who's stealing drugs, the person who falsifies records. You have to be very clear that Just Culture doesn't compromise holding individuals accountable for their behavior; it just reframes how we look at the situation.

**What were the steps the Board took to get to this point?**

There were four. First, was a philosophical shift away from "blame and shame." Next, came the implementation of the PREP program with a focus on quality improvement. Then we needed to align our strategic initiatives with the Just Culture. And finally, we're putting Just Culture into our daily work.

I've learned three lessons from this experience. First and foremost, you must believe that Just Culture is the "right" approach to take to promote learning and maintain accountability. Second, if you believe in Just Culture, you must invite the "right" people to the table to decide how you can best implement it; you will need the support of creative leaders, both formal and informal. Third, every state (and healthcare setting) is different, so you will need to develop strategies that can and will ensure your success at a local level.

**How will you know when the vision is fully implemented?**

My vision would be that when it's fully implemented, it will simply be the way we do business in healthcare. I'll know we've changed the culture when our shared norms for dealing with errors are trust, honesty, and moving quickly to address the few individuals who aren't safe and are reckless. Then we'll all be playing from the same game plan. It takes time to disseminate Just Culture; we need to start teaching it in nursing and medical schools too. I suspect that it will take North Carolina at least five years to change its culture, but we have a good start on it.

**Thank you for sharing your experiences with us, Julie.**

*Sharon Comden, Dr.PH*

# An Examination of Red Rules in a Just Culture

In recent months, several members of the Just Culture Community have questioned whether implementing “red rules” is a desirable strategy in a Just Culture. Many high-consequence organizations have considered the option of implementing red rules to improve organizational safety performance. Specifically within healthcare, the Agency for Healthcare Research and Quality (AHRQ) defines and discusses red rules in the following manner:

**Red Rules** - Rules that must be followed to the letter. In the language of non-health care industries, red rules “stop the line.” In other words, any deviation from a red rule will bring work to a halt until compliance is achieved. Red rules, in addition to relating to important and risky processes, must also be simple and easy to remember.

An example of a red rule in health care might be the following: “No hospitalized patient can undergo a test of any kind, receive a medication or blood product, or undergo a procedure if they are not wearing an identification bracelet.” The implication of designating this a red rule is that the moment a patient is identified as not meeting this condition, all activity must cease in order to verify the patient’s identity and supply an identification band.

Health care organizations already have numerous rules and policies that call for strict adherence. So what is it about red rules that makes them more than particularly important rules? The reason that some organizations are using this new designation is that, unlike many standard rules, red rules are ones that will always be supported by the entire organization. In other words, when someone at the frontline calls for work to cease on the basis of a red rule, top management must always support this decision. Thus, when properly implemented, red rules should foster a culture of safety, as frontline workers will know that they can stop the line when they notice potential hazards, even when doing so may result in considerable inconvenience or be time consuming and costly for their immediate supervisors or the organization as a whole.

To assess the effectiveness of red rules, we must first understand the outcome we desire once we implement them. According to the above, “red rules should foster a culture of safety” within the organization. In the context of Just Culture, this infers added value to an

organization’s ability to improve system design and influence the behavioral choices of staff.

## Safe Systems

Will the implementation of red rules lead to better, more reliable systems? When work processes cease due to red rule non-compliance, there would seem to be a strong incentive to improve the process, equipment or procedure involved. If adherence is mandatory before operations continue, then you could say that the system has been “fixed,” at least temporarily. Repeated occurrences would likely lead to more permanent fixes, including engineering controls and system re-design. In these cases, red rules have the potential to focus attention on system vulnerabilities and known hazards, thereby offering improvements to existing conditions.

## Safe Choices

The effectiveness of a red rule as an incentive to human behavior would seem to depend on whether violation of the rule results in certain consequences, such as a high likelihood of an adverse outcome or immediate punishment. For this to happen, compliance with the rule must be monitored at all times. If not, then our experience shows us that individuals will be susceptible to drifting into at-risk behavior, even when red rules are in place.



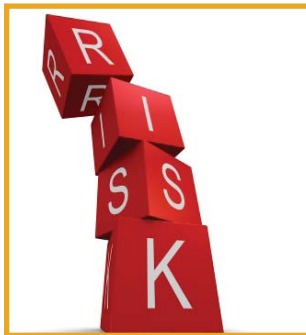
## The Just Culture Model

The Just Culture Algorithm does not refer to red rules, *per se*. In general, Just Culture can be described as a risk-based, rather than rule-based, approach to organizational performance. Experience has shown that rules themselves are generally weaker than other, more powerful incentives. Often the desire to save

## An Examination of Red Rules in a Just Culture (continued)

time, or do more with less, can lead us to overlook rules in favor of risk taking behavior (e.g., nurses skipping a two-patient-identifier procedure, pilots not receiving independent verification from a second pilot before accepting a clearance to cross or takeoff on an active runway, speeding while driving a car).

A key component of success in a Just Culture is the ability to draw the “bright line” between at-risk and reckless behaviors whenever an organization recognizes significant risks. However, one concern is that an organization might rely on too many red rules and become rule-dependent, rather than recognizing circumstances where violating a rule, even a red rule, may be the best course of action. In aviation, we recognize that airmen may deviate from all federal aviation regulations to the extent necessary to meet the conditions of an emergency.



*14 CFR 91.3 (b) states:*

*In an in-flight emergency requiring immediate action, the pilot in command may deviate from any rule of this part to the extent required to meet that emergency.*

Can red rules accommodate such action? Is there any rule which is so well-crafted or understood that it is intended never to be broken under any circumstance by anyone? Perhaps so, but in these circumstances it is likely considered a natural law or social norm. Consider unwarranted violence, sexual harassment, or illicit drug and alcohol use in the workplace. Each of these is widely viewed as intolerable behavior today. Red Rules can perhaps be useful in guiding the transition between behavior that was tolerated in the past, but the organization now considers to be reckless. Our general obligation to avoid these types of behaviors is included in the Just Culture Algorithm under the Duty to Produce an Outcome, where the system by which compliance occurs is largely within the control of the employee. The second duty contained in the Algorithm is the Duty to Follow a Procedural Rule, where the system is largely controlled by the employer.

Within the Just Culture Algorithm, the highest duty, the one that takes precedence over all others, is the Duty to Avoid Causing Unjustifiable Risk or Harm. It is in the context of this duty that we ask detailed questions regarding the employee’s behavioral choice. In this part of the Algorithm, we judge the individual by an objective, versus subjective, standard. Our approach is to assess whether there was a “conscious disregard of a substantial and unjustifiable risk.” By taking this approach, we are applying the same standard to any reckless behavior or event, independent of actual outcome. By implication, red rules would fall into this category of duty. Using AHRQ’s terms, red rules involve “important and risky” processes. Non-compliance with a red rule, then, would surely be deemed “substantial and unjustifiable risk.” It would then be necessary to determine if the non-compliant individual was “conscious” of the red rule being broken. If so, such behavior would be considered reckless, both under the obligation to comply with the red rule and when examined using the Just Culture Algorithm.

In our view, the desire to implement red rules is well-intended, but may not be the most effective approach to human error and systems management. While red rules promise the potential for improved systems reliability, their ability to influence human behavior beyond what is possible through other measures remains in question. Alternatively, in a Just Culture, the Duty to Avoid Causing Unjustifiable Risk or Harm achieves the same goal intended for red rules: to improve organizational performance through recognition and management of risk. The advantage we perceive the Duty to Avoid Causing Unjustifiable Risk or Harm has over red rules is that it applies equally to any high risk activity that has the potential to cause unjustifiable harm, not just a select few. One of the hallmarks of a Just Culture is that any such risk would be treated the same as a red rule. When an employee raises their hand to identify a substantial risk that does not align with the values of the organization, the activity should cease until the dilemma is resolved or the risk mitigated. As such, the Duty to Avoid Causing Unjustifiable Risk or Harm could be thought of as not only the highest duty, but in essence, it is the only red rule considered universal among all Just Culture organizations.

*Scott Griffith, MS*

# Community Newsbriefs

## FALL 2007 PUBLIC COURSE SUCCESS

We recently completed the Fall 2007 Just Culture Public Course, welcoming leaders in the healthcare, aviation and nuclear power industries.

David Marx, President and founder of Outcome Engineering and the Just Culture Community and Scott Griffith, Chief Operating Officer of Outcome Engineering, led the course and provided practical tools for attendees to take with them to their organizations.

We appreciate the enthusiastic response of the participants, making this course a continuation of the building momentum of the Just Culture Community. Outcome Engineering is committed and working with attendees, past present and future in partnering with them on their Just Culture journey.

## JUST CULTURE in EUROPE

The Just Culture concepts were presented at the 36th session of the assembly of the International Civil Aviation Organization (ICAO) held on September 18-28, 2007. The state of Portugal presented a working paper on Just Culture on behalf of the European community and its member states. In its proposal, Portugal suggested actions to support implementation of Just Culture within the worldwide aviation community.

# Calendar of Public Events

Listed below are conferences where Outcome Engineering representatives are scheduled to speak. Please visit these organization's website for further information.

**December 12, 2007**

Scott Griffith will train the Missouri Statewide Just Culture Initiative Stakeholders. Jefferson City, MO.

**January 30, 2008**

David Marx to present PRA and Just Culture at the PSIC 2008 Conference

**February 11, 2008**

David Marx to speak around his upcoming book at the 2008 Association of California Nurse Leaders program, Rancho Mirage, CA.

**March 5, 2008**

Scott Griffith will present "Just Culture Implementation on "An Examination of Red Rules" at the Catholic Health Initiatives 2008 Quality and Risk Management Group Conference, San Antonio, TX.

# Building Our Community

Are you:

- A systems engineer?
- A public policy wonk?
- A pilot, doctor, or nurse?
- A seasoned facilitator?
- A human factors specialist?
- A great public speaker?
- A mathematician or physicist?
- A human resources specialist?
- A "can-do" person?
- An experienced safety or risk officer?
- A creative and professional writer?
- A lawyer?
- A teacher and coach?
- A person with a passion to make the world a better place?

OK, maybe you do not possess all of these qualifications, but if you do have some, we want to hear from you. Outcome Engineering, Curators of the Just Culture Community, is seeking additional professionals to join our team. We're developing and implementing safety culture and risk management tools across high-risk industries - from healthcare and aviation, to railroads, nuclear power and space exploration. As a consultant, you would work with clients in developing organizational cultures that minimize and mitigate the risk of harm to their customers and staff. We want to make the world a safer place to live, and we want you to help. For more information, contact Scott Griffith at [sgriffith@outcome-eng.com](mailto:sgriffith@outcome-eng.com).

# Just Culture Training

Our Just Culture course is the entry point for those seriously desiring to change their organizational culture through the use of Just Culture Community tools.

You will find that the course provides the foundation for how risk should be managed, both *before* and *after* the adverse event, and across all organizational values, not just safety.

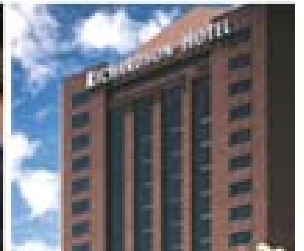
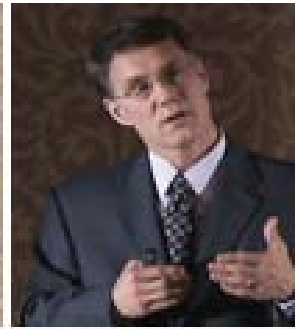
Our experience shows that those who send a cross functional team will be best positioned to develop and nurture these concepts as they work together to lead their organization in its change process.

Please feel free to contact our office with any questions about our course at 214.778.2010, or sign up online at [www.justculture.org](http://www.justculture.org).

You may also download our registration packet linked at [www.justculture.org/.....](http://www.justculture.org/.....)

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\$595 for the first person, \$495 for each additional attendee registering from the same organization at the same time. Registration deadline is April 10, 2008. Register before February 19th and save \$50.



## Course Topics

- ✚ Introduction to Just Culture
- ✚ Building a Safety Culture
- ✚ Building a Learning Culture
- ✚ Managing System Design
- ✚ Managing Behavior
- ✚ Event Investigation and Data Analysis
- ✚ Just Culture Algorithm
- ✚ Organizational Implementation



Course Date  
April 15-16, 2008  
Dallas, TX

# Community Update

When the Just Culture Community™ (www.justculture.org) was launched in October 2005, the mission was to bring together people from across diverse industries as they worked toward a common goal of building a safety-supportive, open-learning environment within their organization. Two years later, the community site has grown to provide education, resources and tools to assist community members in their journey toward a Just Culture.

As Curators of the Just Culture Community, Outcome Engineering has redesigned the community website from the ground up in order to improve the quality and usability of these resources and tools. This new site was launched in July 2007. Starting with a completely new site design, resources and information are now easier to find. The quarterly community newsletters are easily accessible in PDF format or readable online. The community forum has been tightly integrated with other site features. A new “My Account” page has been designed as a visual dashboard of all products, services and account information. The membership structure of the community has also been completely reworked to provide more accessible content to all users.



A new Just Culture for Managers™ training program is also available. This new educational course includes 4 hours of multimedia online training plus a 100-page workbook. This course corresponds to the new Algorithm (version 3.0) that is easier to use and includes specific guidance on repetitive human errors and repetitive at-risk behaviors. At the end of the course, a custom course certificate can be printed or saved for your use.

We hope these changes will serve to better assist you in your journey toward a Just Culture. As always, we appreciate your feedback and suggestions on all products and services that we offer. Please feel free to email us at [info@justculture.org](mailto:info@justculture.org).

Outcome Engineering  
*The Curators of the Just Culture Community*

