Policy Title:	Just Culture		
Location:	Leadership	**Department:**	Leadership
Policy Number:	Policy Number	**Review Date:**	7/9/2019
Original Effective Date:	7/12/2019	**Current Effective Date:**	7/12/2019

I. Scope:

This is a Facility-wide policy and applies to all employees, physicians, contract workers, students, and volunteers or any other person acting on behalf of ("Facility") (collectively known as staff).

II. Purpose:

The purpose of this policy, and the principles contained herein, is to identify the Facility's commitment to a Just Culture.

The Facility recognizes a Just Culture will improve patient safety and the delivery of quality care by encouraging reporting of safety events, near misses, and hazardous conditions and by facilitating a Facility-wide commitment to patient safety. Our Just Culture recognizes the inevitability of human error, does not punish individuals for system failures for which they have no control, and promotes a non-punitive learning environment; however, our Just Culture also holds Facility staff accountable for individual decision-making and actions. To this end, the Facility will balance systemic factors alongside accountability for individual actions to achieve a consistent, fair, and systematic approach to patient safety improvement.

III. Definitions:

Just Culture: Recognizes that competent professionals make mistakes and acknowledges that even competent professionals will develop unhealthy norms (shortcuts, "routine rule violations"), but has zero tolerance for reckless behavior. (from AHRQ)
Patient Safety: The reduction of preventable errors and adverse events affecting Facility patients.
Patient Safety Event: An unplanned or unexpected event that reaches a patient and results in no harm, some level of harm (minimal to severe), or death.
Near Miss: An event that could have caused harm to a patient but was prevented from reaching the patient.
Hazardous Condition: A situation or circumstance that could lead to a patient safety event or near miss if not corrected.
Malevolent or Willful Conduct: Actions taken by a Staff member with a specific intent to cause harm.
Medical Condition/Ill Health: A physical or mental condition, acute or chronic (including a substance use disorder), that affects an individual's decision-making/actions or ability to perform his/her duties safely.
Negligent Behavior: A failure to behave at the level of care that someone who has the same knowledge and skills would have exercised under the same circumstances.

Reckless Behavior: A behavioral choice to consciously disregard a substantial and unjustifiable risk.
Unsafe Behavior (also known as At-Risk Behavior): A behavioral choice that increases patient safety risks where the risk-taking behavior is not recognized or is mistakenly believed to be justified.
Unintended Human Error: Inadvertently doing other than what was intended: a slip, lapse or mistake.
System Failure: Pre-set policy, procedure and practice that does not achieve the result or outcome intended.
Deliberate Act Test: Assesses whether the individual intended the actions and if the intended actions were malicious.
Incapacity Test: Assesses whether the individual had ill health or a medical condition, including a substance use disorder, which affected his/her decision-making/actions or ability to perform his/her duties safely.
Foresight Test: Assesses whether the individual failed to follow policies, procedures or protocols, and if so, whether those policies, procedures and protocols were sufficient to support appropriate decision-making/actions, or if the individual made a choice involving an unacceptable risk and if there were any mitigating circumstances to the individual's choice.
Substitution Test: Assesses whether a similarly experienced and trained individual would make the same choice under the same circumstances, and if no, considers possible deficiencies in training, experience or education.
History of Unsafe Acts/Unintentional Rule Breaking: Incorporates the individual's historical decision-making/actions into the current review process to the extent applicable to identify a trend of unacceptable behaviors or actions.

IV. Just Culture Principles:

Shared accountability: A non-punitive, learning environment in which the Facility bears responsibility for systemic factors affecting patient safety and for treating Staff members fairly; Staff members bear equal responsibility for exercising good judgment and for speaking up about system opportunities, patient safety events, near misses, and hazardous conditions.

Human Errors: Healthcare delivery is a human endeavor and errors occur despite the education, training, skills, knowledge, and experience of Staff members. Most errors result from breakdowns in the Facility's systems and processes and not from individual misconduct, regardless of the harm incurred.

Second Victims of Error: Staff who experience trauma, guilt, and loss of confidence after involvement in a patient safety event or near miss.

Non-punitive reporting: All Staff members are encouraged to identify and report system deficiencies, patient safety events, near misses and hazardous conditions. Facility leadership encourages Staff reports and no individual will be retaliated against (discipline, demotion, dismissal, etc.) for submitting a report.

Learning Environment: Our Just Culture focuses on identification, discussion, learning and sharing of lessons learned from safety events, near misses and hazardous conditions.

Our learning environment is multidisciplinary, collaborative, and respectful with the dual aims of system improvement and reduction of similar occurrences in the future.

System failures versus individual actions: Our Just Culture does not mean the absence of individual accountability for decisions and actions made by staff members within the performance of their job responsibilities. A Just Culture does mean that staff members will not be blamed when system failures and errors for which they have little or no control do occur.

Individual Accountability: Our Just Culture does not tolerate conscious/willful disregard of risk, recklessness, or negligence. Examples of such behaviors include (but are not limited to): illegal acts; purposefully unsafe, reckless or negligent acts; acts committed under the influence of alcohol or other substances or involving drug diversion; persistent or recurring performance issues despite prior performance improvement efforts; knowingly or willingly concealing a patient safety event. Individuals exhibiting these behaviors or committing these acts will be subject to disciplinary action, up to and including termination.

V. Policy and Procedures:

A. Organizational Responsibilities

C-Suite/Administration Responsibilities:

1. Patient safety is a core value of the Facility.
2. Develop and implement systems and processes that focus on improving patient safety but also recognize human errors as inevitable components of healthcare delivery.
3. Hold individuals accountable for their actions based on the quality of decision-making rather than the outcomes of decisions.
4. Develop and implement high reliability communication strategies to ensure feedback on systems and processes (e.g. safety huddles, leadership rounding, and Good Catch programs).
5. Understand how normalization of deviance develops and utilize effective communication strategies to identify and eliminate normalization of deviance. Normalization of deviance is the institutional acceptance of unsafe routines and practices such as shortcuts, work-arounds, and routine rule violations.
6. Ensure all event reports are investigated and utilize root cause analysis teams when indicated to identify the causal factors leading to the events.
7. Provide support and resources to the root cause analysis teams to ensure appropriate identification and elimination/mitigation of causes of events.
8. Develop a report back loop to report all findings and improvement actions to Staff who have reported a safety event, near miss, or hazardous conditions (trust/report/improve cycle of safety improvement).
9. Provide and encourage utilization of systems to support Staff who are second victims of safety events or near misses.

Directors/Managers Responsibilities:

1. Patient safety is a core value of the Facility.
2. Implement high reliability communication strategies within their units/departments to achieve the trust/report/improve cycle of safety improvement (e.g. safety huddles).
3. Encourage Staff to identify and submit event reports for system deficiencies, safety events, near misses, and hazardous conditions. Recognize those Staff members who do report.
4. Participate in leadership rounding, root cause analyses, and in the development of safe systems and processes.
5. Reinforce safe behavioral choices of staff and continually teach Staff about the importance of safety systems to counter normalized deviance within the unit/department.
6. Report back to Staff on all findings and improvement actions taken resulting from identified system deficiencies, safety events, near misses, and hazardous conditions.
7. Hold individuals accountable for their actions based on the quality of decision-making rather than the outcomes of decisions. Utilize the Just Culture Algorithm attached hereto for evaluation of Staff actions when reviewing safety events or near misses. After reviews are completed, implement the following actions based on the Algorithm outcome: .
    a. System failures: Console the Staff member(s) to mitigate second victim effects and offer Employee Assistance Program (EAP) counseling or other support resources.
    b. Unintended human errors: Console the Staff member(s) to mitigate second victim effects and coach, mentor, or retrain as needed to improve individual performance. Implement a formal performance improvement plan if indicated.
    c. Unsafe, reckless, or negligent behaviors: Coach the Staff member(s) and utilize formal improvement training, focused supervision, or disciplinary actions as needed to correct unacceptable behaviors. Advise Human Resources/Medical Staff of the performance issues identified and participate in HR/Medical Staff corrective action processes as requested. Report performance issues to external oversight agencies as applicable.
    d. Suspected ill health/medical conditions, including substance use disorders: Reference applicable Human Resources/Medical Staff policies and procedures. Advise Human Resources/Medical Staff of the suspected issues and participate in HR/Medical Staff processes as requested. Report performance issues to external oversight agencies as applicable.
    e. Malevolent/Willful Misconduct: Advise Human Resources/Medical Staff of the performance issues identified and participate in HR/Medical Staff corrective action processes as requested. Report performance issues to external oversight agencies as applicable.

Individual Responsibilities:

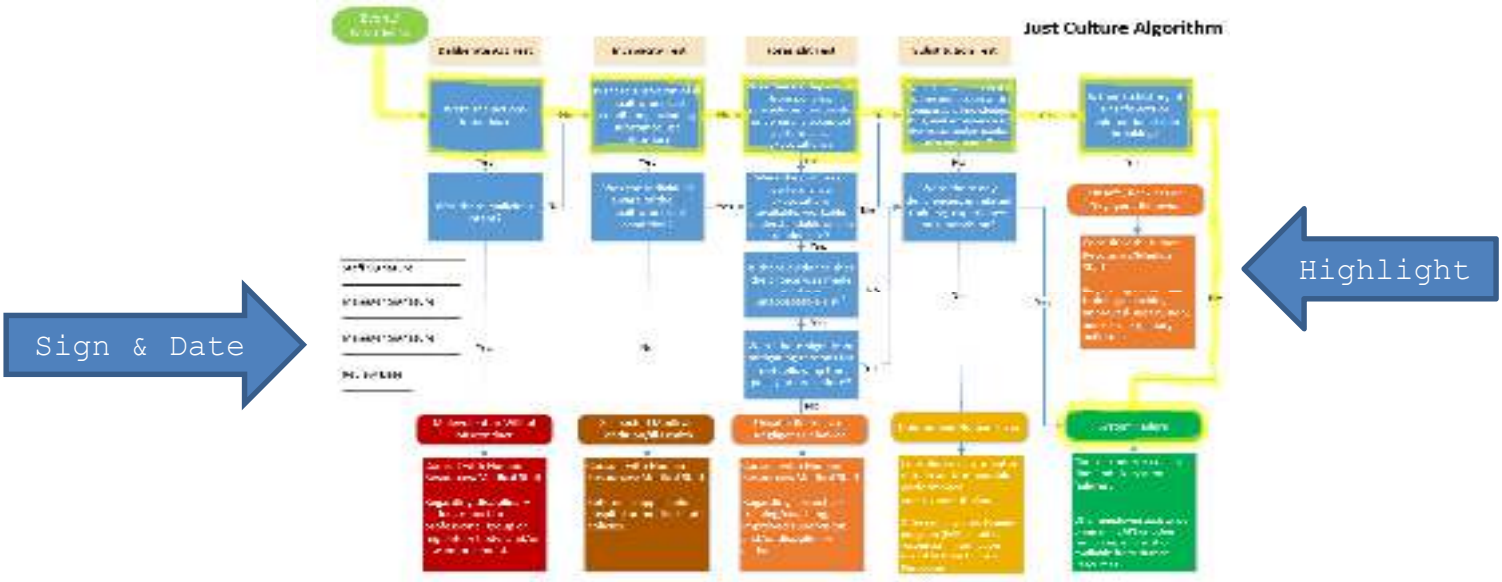
1. Patient safety is a core value of the Facility.
2. Acknowledge that all individuals make mistakes and that to err is human.
3. Acknowledge the trauma, guilt, and loss of confidence experienced by secondary victims of patient safety events.
4. Use critical thinking and situational awareness to avoid or stop unintended human errors from reaching patients; use CUS Tool/"Stop The Line" assertive statements to stop treatment activities if needed to address and resolve patient safety concerns; escalate patient safety concerns to the individual's chain-of-command if treatment activities continue despite unresolved safety concerns.
5. Report safety events, near misses and hazardous conditions utilizing the event reporting system.
6. Report safety events, near misses and hazardous conditions utilizing direct communication with your manager, safety huddles and leadership rounding.
7. Ask for feedback on the safety events, near missies and hazardous conditions you have reported.
8. Participate in the development of safe systems and promote the trust/report/improve cycle of safety improvement.
9. Understand your individual assignments and exercise good judgment in caring for patients; ask questions when something is new or you are unsure of what needs to be done.
10. Follow policies, procedures and protocols and refrain from normalization of deviance.
11. Speak up when you identify a patient safety concern or see someone doing something that does not seem right.
12. Cultivate a Facility-wide culture of safety, act in a professional and cooperative manner, and treat others with respect, courtesy, and dignity.

B. Review and Evaluation Procedures When a Safety Event or Near Miss is Identified:

1. Staff involved will submit an Event Report through the MIDAS system.
2. Facility-specific policies regarding Patient Safety Event Reporting and Sentinel Events will be followed for investigation, classification and follow up, including a root cause analysis if indicated.
3. The Staff member(s) will meet with a team of at least two managers/clinical supervisors/equivalent, including their direct supervisor/department chair, to review the actions of the Staff member(s) utilizing the Just Culture Algorithm attached hereto.
4. The Facility's Just Culture Algorithm will be utilized to guide discussion of what happened, analysis of the conditions and milieu at the time of the event/near miss, and evaluation of the decision-making and actions of the Staff member(s) involved.
5. The outcome of the event, i.e. the extent of harm to the patient whether none, some level of harm or death, should never be a factor in the evaluation and

application of the Just Culture Algorithm. The staff's decision-making and actions are evaluated, not the result of the decision-making and actions.

6. Upon conclusion of the review, the review team will produce flowcharts highlighting the flow of the conclusions based on the Algorithm's criteria for each Staff member involved, and each flowchart will highlight the arrows and boxes applicable to that specific Staff member's evaluation. Each Staff member and managers involved in the review will sign and date the highlighted Algorithm generated with respect to that Staff member.



7. A copy of the highlighted Algorithm will be given to the Staff member and a copy will be sent to Human Resources/Medical Staff Office for filing in the staff member's file.
8. If the outcome is a determination of Malevolent/Willful Misconduct, Suspected Ill Health/Medical Condition, Unsafe/ Reckless/Negligent Behavior, then the managers involved must advise Human Resources/Medical Staff Office of the outcome and participate in subsequent HR/Medical Staff processes as requested. Managers will review applicable reporting standards and will report outcomes as needed to external oversight agencies.
9. If the outcome is a determination of Unintended Human Error or System Failure, then the management team will console Staff involved, communicate system improvements to all Staff, and ensure that Staff are notified of EAP counseling and other resources available from Human Resources to mitigate second victim effects.
10. The management team will communicate the conclusion of the Algorithm review to the root cause analysis team to ensure pertinent causal factors are included in the root cause analysis process. Follow up actions conducted with the staff member are confidential and will not be communicated to the root cause analysis team.
11. The management team will also communicate the conclusion of the Algorithm review up the chain of command, as well as to the Just Culture Sustainment Team, for oversight and monitoring.
12. All participants will maintain the confidentiality of the review process.

C. Initial Implementation and Ongoing Education:

A. Facility Leaders, Managers, and Staff will complete initial education and training as assigned in connection with adoption of this Policy to achieve a consistent, fair, and systematic approach to patient safety improvement.
B. Just Culture policy education will be assigned for all new employees or contracted staff and at least annually thereafter.
C. Just Culture policy education will be incorporated into current orientation and annual mandatory education processes.

D. Just Culture Sustainment:

1. A Just Culture Sustainment Team will be formed and will actively monitor the Facility's Just Culture through the development and implementation of process and outcome measures.
2. The Just Culture Sustainment Team will include at a minimum the CEO, COO, CNO, CMO/Medical Director, and Directors of Quality, Risk and Human Resources.
3. The Just Culture Sustainment Team will meet quarterly.
4. Process and outcome measures to be implemented by the Just Culture Sustainment Team include
    a. Completion of Just Culture education by all staff
    b. Use of the Just Culture Algorithm
    c. Outcome/decision making involving the Just Culture Algorithm.
    d. Monitor and improve the Serious Safety Event Rate
    e. Other measures as requested by Corporate Patient Safety Council.

D. In addition to its monitoring activities, the Just Culture Sustainment Team will be responsible for the ongoing promotion of Just Culture, in collaboration with the Corporate Patient Safety Council. Promotional activities may include open discussions with staff in a variety of venues, use of posters and other promotional items, Good Catch programs, and/or periodic news articles.

VI. References:

Barger, D., Charney, F. (2011) Gap Assessment of Hospitals' Adoption of the Just Culture Principles. Pennsylvania Patient Safety Advisory. 8(4):138-143.

Clapper, C, Merlino, J, Stockmeier, C (2018). Zero Harm: How to Achieve Patient and Workforce Safety in Healthcare. 7: 141-160.

Institute of Medicine: *To Err is Human: Building a Safer Health System.* Washington, DC: National Academy Press, 2000.

Marx, D. (2012) Just Culture Algorithm v3.2.

Reason, J. (1997) Decision Tree for Determining Culpability of Unsafe Acts.

VII. Related Policies:

711. Patient Safety Event Reporting. 2018

712. Sentinel Events. 2015

Facility's Employee Conduct Policies

Facility's Corrective Actions Policies

Policy Behaviors That Undermine a Culture of Safety

Facility's Medical Staff Bylaws, Rules and Regulations

Facility's Peer Review Policies