**Policy Statement**

Fulton County Medical Center is committed to creating and sustaining a Just Culture by consistently and transparently assessing work systems and processes, as well as individual actions and decisions, in the aftermath of a safety event. If any provision of this policy conflicts with a collective bargaining agreement, enforceable standard or regulation, the collective bargaining agreement, standard or regulation supersedes.

**Purpose**

The purpose of this policy is to describe the process for supporting a Just Culture by balancing system and individual accountability in a manner best supporting the safety of patients and staff.

**Scope**

This policy applies to all employees of the Fulton County Medical Center.

**Definitions**

* **Just Culture**: An atmosphere where:

1. Leaders and staff understand that safety and performance improvement depend on the ability to learn from mistakes and that any process viewed as unjust prevents information from being brought forward for learning and prevention.
2. Everyone recognizes that most errors have many causal factors and may not be due to the actions or decisions of a single person.
3. Everyone acknowledges that when an individual may hold some degree of accountability, a fair, equitable, and transparent method of determining accountability is applied.
4. Team members speak freely and share information, understand the systems and processes that guide actions, and are confident that action will be taken to address identified risks in work systems and processes.

* **Just Culture Algorithm Endpoints**:

The product of the Just Culture Algorithm process, yielding one of three endpoints:

* + 1. **System Induced/Human Error**: The product of the system’s current design, involving inadvertent or unintentional decisions or actions that caused, or could have caused an undesirable outcome.
    2. **At Risk Action:** An action that increases risk where risk is not recognized (unintentional) or is mistakenly believed to be justified.
    3. **Reckless Action:** A choice to consciously disregard a substantial and unjustifiable risk, including, but not limited to, sabotage, malevolent damage, patient abuse, and fraud.
* **System:** A set of interdependent elements interacting to achieve a common aim. These elements may be both human (i.e. communication, teamwork), and non-human (i.e. work environment, equipment, technologies, policies and procedures, delivery systems).
* **Safety Event:** An event, incident, or condition that resulted or could have resulted in harm to a patient.

**Provisions/Procedures**

1. The Just Culture Algorithm process is to be used following an assessment/analysis of an event which reveals concern that, in addition to system and process issues, an individual may hold causal responsibility.
   1. The goal is fair and just management of the critical elements within our control: designing safe systems and helping people to make safe decisions and choices.
   2. Referrals to the Just Culture Core Team from:
      1. Root Cause Analysis (RCA) Recurrence Prevention Recommendation
      2. Department Managers
      3. Event Reporting Patient Safety Team
      4. Safety Team
      5. Patient Safety Committee
      6. Board Recommendation, etc.

Just Culture Core Team Members/participants shall include:

* Co-Facilitators with training and experience in incident analysis and the Just Culture algorithm (one from Quality/Risk/Safety and one from Clinical Operations)
* Human Resources (HR) representative

Additional participants can be involved as needed:

* Functional Operational leader (above the direct manager/supervisor)
* Direct manager/supervisor
* Labor representative (if individual involved is represented by a union)
* Involved individual

Complete the process by following the Just Culture Algorithm Guidance Document (Appendix 1 & 2) to determine an end-point and identify corresponding management practices.

**References/Appendices**

* **Appendix 1:** Just Culture Algorithm
* **Appendix 2:** Just Culture Guidance Document
* **Appendix 3:** CHART Institute Just Culture Training Curriculum
* **Appendix 4:** Reference List

No

No

No

Yes

Yes

Yes

No

No

No

Yes

Yes

Yes

No

Yes

No

No

Yes

No

Yes

System Induced Human Error

Reckless Action

Yes

At Risk Action

Algorithm Guidance Document

Purpose

Constant change in healthcare requires that those delivering care adapt to the complex environments and dynamic conditions presented by patients, technologies, information and processes. Adaptation requires recognition of the risks in our systems and commitment to making those systems as safe as possible. The ability to identify systemic risks and implement sustainable mitigations requires transparency and trust. Staff must feel safe sharing information about the conditions of work and the challenges they face delivering care, including errors and mistakes made or witnessed, without fear of unjust blame.

The purpose of this document is to provide insight and guidance regarding the process for determining and managing accountability in the aftermath of a Safety Event. In doing so, we differentiate what is caused by gaps or failures in the system from what is caused by human actions and choices, balancing system and individual accountability to support patient safety.

The Just Culture Algorithm process is to be used when incident analysis reveals concern that, in addition to system and process issues, an individual’s actions or decisions may hold significant causal responsibility. The goal is fair and just management of the critical elements within our control—designing safe systems and helping people make safe decisions and choices. The desired outcome is the protection of patient safety, improvement of systems and prevention of harm.

This process is to be conducted as part of your Quality Assurance and Performance Improvement (QAPI) program. As your quality assurance team reviews and acts on the suggestions, it is important to follow your facility’s confidential QAPI processes and state-specific peer review, quality work product and confidentiality statutes.

Expectations

Leadership and Management in a Just Culture

* Create and sustain an atmosphere of trust that supports a commitment to learning and designing safe, efficient systems and processes
* Encourage and support speaking-up and formal reporting of incidents and near misses
* Respond to reports of incidents, near misses and recommended solutions in a prompt and thorough manner
* Participate in incident analysis and use a standard approach for managing involved staff

Staff in a Just Culture

* Look for risks in systems, processes, procedures and choices
* Report hazards, incidents, near misses and adverse events
* Participate openly and honestly in incident analysis
* Participate openly and honestly as a peer in the substitution test

Definitions

Drift:When noncompliance becomes the norm, and the perception of risk fades or is believed to be justified. Also known as normalization of deviance.

Just Culture: An atmosphere where:

* Leaders and staff understand that safety and performance improvement depend on the ability to learn from mistakes and that any process viewed as unjust prevents information from being brought forward for learning and prevention
* Everyone recognizes that most errors have many causal factors and may not be due to the actions or decisions of a single person
* Everyone acknowledges that when an individual may hold some degree of accountability, a fair, equitable and transparent method of determining accountability is applied
* Team members speak freely and share information, understand the systems and processes that guide actions, and are confident that action will be taken to address identified risks in work systems and processes

Just Culture Algorithm:   
An agreed set of principles for drawing the line between acceptable and unacceptable actions or decisions that is applied when an incident analysis reveals that individual actions or decisions may warrant accountability. Use of the algorithm results in one of three endpoints**:**

* **System Induced/Human Error:** The product of the system’s current design, involving inadvertent or unintentional decisions or actions that caused, or could have caused, an undesirable outcome
* **At Risk Action:** An action that increases risk where risk is not recognized (unintentional) or is mistakenly believed to be justified
* **Reckless Action:** A choice to consciously disregard a substantial and unjustifiable risk, including, but not limited to, sabotage, malevolent damage, patient abuse and fraud

Learning Culture:   
An atmosphere where staff learns from safety events, recognize risks and are committed to making systems as safe as possible. Organizational benefits of a learning culture include, but are not limited to:

* Increased efficiency and safety
* Increased employee satisfaction and engagement
* Developed sense of ownership and pride
* Enhanced ability to adapt to change
* Stronger, more confident communities of practice

Safety Event:An event, incident or condition that resulted or could have resulted in harm to a patient.

Similarly-Trained Peer: An individual with the same license and/or certificate, working in the same or a similar department/unit, possessing like skill sets and responsibilities, and/or with like classifications or job code. A peer must have completed their probationary period, have full-time or part-time employment status, not be involved in a performance improvement plan or other disciplinary action, not be related to the individual in question and not be involved in the incident.

Situational Awareness:  
Being aware of one's surroundings and identifying potential threats and dangerous situations

Substitution Test:   
Also known as the "reasonable person test", this test asks the question “Would another individual coming from the same professional group, possessing comparable qualifications and experience, be likely to draw the same conclusions or make the same decisions or choices given the context and facts available at the time?”

System:  
A set of interdependent elements interacting to achieve a common aim. These elements may be both human (i.e. communication, teamwork), and non-human   
(i.e. work environment, equipment, technologies, policies and procedures, delivery systems).

Algorithm Instructions

Use the process outlined below to determine individual and/or organizational accountability in the aftermath of a safety event when an event analysis reveals concern that, in addition to system and process issues, an individual’s actions may hold causal responsibility.

Participants in this process should include:

* Co-Facilitators with training and experience in incident analysis and the Just Culture algorithm (one from Quality/Risk/Safety and one from Clinical Operations)
* HR representative

Additional participants may be involved as needed:

* Functional Operational leader (above the direct manager/supervisor)
* Direct manager/supervisor
* Labor representative, if individual involved is represented by a union
* Involved individual

Step 1

The first line of questioning examines intent, asking “**Were the actions as intended?”**.In other words, was the action or omission deliberate? If the answer is yes, ask **“Was the outcome as intended?”**.This question determines if the person acted knowing the consequences of the action. A ‘yes’ response to both questions results in a Just Culture Endpoint of Reckless Action.

Step 2

If the answer either of the questions in Step 1 is no, the next question is **“Was there a suspicion of impairment?”**, and if so, “**Was substance use or abuse involved?”**. A ‘yes’ response indicates that the person was under the influence at the time the incident occurred. It is then necessary to determine if the person was taking prescribed medication for a medical condition. If the person was not taking prescribed medication for a medical condition, the Just Culture Endpoint is Reckless Action. If the person was taking prescribed medication for a medical condition, the Just Culture Endpoint is At Risk.

Step 3

If the person was not under the influence of drugs or alcohol, the next question is **“Did the individual knowingly violate standard operating procedures or practices?”**. To knowingly violate a standard practice or procedure, two conditions must be met:

* The individual must be aware of their responsibility to follow that practice
* The individual must be qualified to have that responsibility

If the two conditions are met, and the answer to the question is no, the process continues to Step 4**.** If the answer is yes, the next question is **“Were the standard practices or procedures available, workable, intelligible and correct?”**.

To answer this question, we must define available, workable, intelligible and correct:

* An *available* standard practice or procedure is provided in writing or through non-written educational means, included in orientation, training, or competency evaluations and routinely observed or monitored for adherence. If an individual is compelled to violate standard practices or procedures by someone in authority, that practice would **not** be considered *available* to the individual*.*
* A *workable* procedure or practice can be followed under normal working conditions and staff must have access to all resources needed to carry out the practice or procedure. It is one that was designed to make it easy to do the right thing and hard to do the wrong thing. A procedure or practice is **not** considered workable if leadership was aware of drift (non-compliance or work-arounds) but did not intervene.
* An *intelligible* procedure or practice is made available in a format that can be understood by those with the responsibility of following it.
* A *correct* procedure or practice agrees with facts or what is generally accepted.

If the answer to this question is no, the Just Culture Endpoint is System Induced/Human Error. If the answer is yes,the process continues to Step 4.

Step 4

When indicated, the next step utilizes the substitution test by asking **“Would another similarly trained peer draw the same conclusions or make the same decisions or choices, given the context and facts available at the time?”**.The substitution test should be presented in the context of the situation in which the event occurred and de-identified to remove personal bias. This step should uncover whether there has been drift from the intended practice and if peers would struggle to complete this practice/procedure under similar conditions. If possible, three similarly trained peers should be utilized.

If any peer answers yes, the substitution test is passed, and the Just Culture Endpoint is System Induced/Human Error. If all peers answer no, the substitution test is failed, and it is necessary to ask, “**Were there deficiencies in training or experience?”**.This question should uncover any recent changes in practices or procedures, cuts in training and/or competency evaluations, and confirm proper oversight of staff. If the answer is yes, the Just Culture Endpoint is System Induced/Human Error. If the answer is no, ask **“Did the person perceive the risk?”**. This question provides an opportunity to understand why the individual considered the questioned action to be the right thing to do under the given circumstances (i.e. did not recognize the risk or believed that the benefit outweighed the risk). If answered yes, the Just Culture Endpoint is Reckless Action. If answered no, the Just Culture Endpoint is At Risk Action.

**Notes:**

* A Just Culture Algorithm Worksheet may be used to document completion of this process
* The algorithm is not intended for use in managing repetitive breaches in protocol adherence, which should be referred to Human Resources
* This process does not replace or eliminate a represented worker’s right to file a grievance according to the terms and conditions of their collective bargaining agreement
* Refer to applicable collective bargaining agreements for appropriate disciplinary/ corrective action for represented worker

Managing in a Just Culture

The following guide should be used to manage each of the identified Just Culture Endpoints:

1. **System Induced/Human Error –** Console the individual and manage the system

**System  
Induced Human Error**

* + **Individual:**
* Console and enlist assistance in mitigating risks
* Discuss recommendations for system-based remedial action to prevent recurrence
  + If a deficiency in training and/or experience was identified, provide and document appropriate training/experience
  + **Systems:**
* Ensure that analysis is conducted to identify and define systems issues and develop and implement sustainable action plans
* Consider the use of safety nets to catch errors before they impact a patient and checklists to prevent reliance on human memory
* Share learnings with colleagues and other appropriate parties
* Communicate changes in policies/procedures, training materials and competency validations

1. **At Risk Action** – Coach the individual and remediate risks

**At Risk Action**

* + **Individual:**
* Coach individual using supportive discussion, role-modeling, mentoring, observations and real-time feedback regarding choices and actions
  + **Systems:**
* Ensure that analysis is conducted to identify and define system issues and develop and implement sustainable action plans
* Consider actions that:
  + remove sources of drift
  + increase situational awareness
  + decrease tolerance for taking risks
  + make it easy to do the right thing
  + make it hard to do the wrong thing
* Share learnings with colleagues and other appropriate parties
* Communicate changes in policies/procedures, training materials and competency validations
  + **Notes regarding substance abuse:**
* Substance abuse should be handled according to organizational policies
* If the person was taking drugs for a medical condition, organizational policies may require him/her to seek treatment from a qualified provider

1. **Reckless Action** – Remedial and/or disciplinary measures

**Reckless Action**

* + **Individual:**
* Refer to the appropriate parties (i.e. senior leadership, human resources, labor relations, security), who will then manage according to organizational policies
* Intentionally malicious actions that do not result in harm or damages due to intervention or luck should be dealt with in the manner stated above as the outcome should not be a determining factor
  + **Systems:**
* In instances where system related issues exist in parallel with individual reckless actions, a thorough, credible analysis should be conducted to identify and define system issues and develop and implement sustainable action plans

Worksheet

**Date:**

**Staff Member:**

**Just Culture Algorithm Team:**

**Quality Leader:**

**Operations Leader:**

**Human Resources Leader:**

**Additional Participants:**

Instructions  
Use to document steps 1-4 of the Just Culture Algorithm process. Refer to the Just Culture Algorithm Policy and Just Culture Algorithm Guidance Document for assistance in fairly and consistently utilizing the algorithm.

Step 1  
Were the actions as intended? (y/n) \_\_\_\_\_\_\_

* If no, go to Step 2.
* If yes, was the outcome as intended? (y/n) \_\_\_\_\_\_
  + If no, go to Step 2
  + If yes, **Reckless Action** has been identified. Please describe your findings and manage according to the Just Culture Algorithm Guidance Document.

Step 2  
Was there a suspicion of impairment? (y/n) \_\_\_\_\_\_

* If no, go to Step 3.
* If yes, was substance use or abuse involved? (y/n) \_\_\_\_\_
  + If no, go to Step 3.
  + If yes, was the substance a prescribed medication for a current condition? (y/n) \_\_\_\_
    - If no, **Reckless Action** has been identified. Please describe your findings and manage according to the Just Culture Algorithm Guidance Document.
    - If yes, **At Risk Action** has been identified. Please describe your findings and manage according to the Just Culture Algorithm Guidance Document.

Step 3  
Did the individual knowingly violate standard operating procedures or practices? (y/n) \_\_\_\_\_

* If no, go to Step 4.
* If yes, confirm that the following two conditions were met:
  + The individual was aware of their responsibility to follow that practice
  + The individual was qualified to have that responsibility
    - If both conditions were not met, go to Step 4.
    - If both conditions were met, confirm that the standard practices or procedures were:
      * Available (y/n) \_\_\_\_
      * Workable (y/n) \_\_\_\_
      * Intelligible (y/n) \_\_\_\_
      * Correct (y/n) \_\_\_\_
        + If yes to all 4, go to Step 4.
        + If no to any of the 4, **System Induced/Human Error** has been identified. Please manage according to the Just Culture Algorithm Guidance Document.

Step 4  
Query up to three similarly trained peers to determine:

Would another similarly trained peer be likely to draw the same conclusions, or make the same decisions or choices, given the context and facts available at the time? (y/n) \_\_\_\_

* If one or more peer replies yes, **System Induced/Human Error** has been identified. Please manage according to the Just Culture Algorithm Guidance Document.
* If all peers reply no, were there deficiencies in training or experience? (y/n) \_\_\_\_
  + If yes, **System Induced/Human Error** has been identified. Please manage according to the Just Culture Algorithm Guidance Document.
  + If no, did the individual perceive the risk? (y/n) \_\_\_\_
    - If no, **At Risk Action** has been identified. Please describe your findings and manage according to the Just Culture Algorithm Guidance Document.

If yes, **Reckless Action** has been identified. Please describe your findings and manage according to the Just Culture Algorithm Guidance Document.

[CLICK HERE](https://www.chartrrg.com/wp-content/uploads/protected/Just-Culture-Worksheet.docx) to download worksheet

(appendix 3)

Supplemental Training Presentations – Curriculum

Just Culture for Frontline Staff

[CLICK HERE](https://www.chartrrg.com/wp-content/uploads/protected/Just-Culture-for-Frontline-Staff.pptx) for PowerPoint presentation

Leading in a Just Culture

[CLICK HERE](https://www.chartrrg.com/wp-content/uploads/protected/Leading-a-Just-Culture.pptx) for PowerPoint presentation