

**Policy No: 5.24**

Subject: Response to Safety Events – Just Culture
Supersedes: All existing corporate and business unit policies on this subject
Effective: October 8, 2008
Revised: July 1, 2002, December 1, 2012
Reviewed: December 1, 2012
Pages: 10
Approved by: Human Resources Executive Team (HRET) & Operational Leadership

1.0 PHILOSOPHY/PURPOSE

Henry Ford Health System believes in a “Just Culture” that encourages employee self-disclosure and continual delivery of high quality services for patients, employees, and the community it serves. HFHS wants employees to feel safe to speak-up and speak-out about reporting of adverse events, near misses, existence of hazardous conditions, and related opportunities for improvement as a means to identify systems changes and behavior changes which have the potential to avoid future adverse events.

We also recognize that employees must balance personal and organizational values with:

- The duty to avoid causing unjustified risk or harm
- The duty to produce an outcome
- The duty to follow a procedural rule

To this end, HFHS believes in a consistent, fair, systematic approach to managing behaviors that facilitate a culture that balances a non-punitive learning environment with the equally important need to hold persons accountable for their actions.

2.0 SCOPE/ELIGIBILITY

This policy applies to anyone working at any HFHS business unit or facility including, but not limited to: regular & contingent employees, physicians, agency staff, volunteers and contract workers.

3.0 RESPONSIBILITY

The interpretation, administration and monitoring for compliance of this policy shall be the responsibility of operational leadership in conjunction with Human Resources, Quality/Risk staff and other departments where necessary.

4.0 POLICY

HFHS takes the position that safety events are not commonly the result of individual misconduct (reckless behavior), but rather system or process failures (human error/at-risk behavior influenced by the system as designed).

All managers and leadership will proactively assure employees that the System's culture promotes reporting of safety events and that such events will be handled consistently and fairly.

As part of the normal investigative process for any safety event, the manager will conduct an investigation to determine the type of behavior that led to the safety event and to distinguish between blameworthy and blameless actions. The safety event will be assessed objectively and analyzed using a systematic approach based on three classifications of behaviors/actions:

1. Human Error
2. At-Risk
3. Reckless

(See Appendix A, Guidelines for Analyzing and Responding to a Safety Event).

Exceptions to this approach will occur if an individual knowingly or willingly conceals a safety event or hinders a safety investigation, or causes a safety event or commits an unsafe act that results from:

1. An illegal act
2. A breach of confidentiality
3. A purposeful or reckless unsafe act
4. An act committed under the influence of alcohol, other substances or involves drug diversion
5. A persistent issue not resolved through performance improvement.

(See Corrective Action Program HR Policy No: 5.17)

5.0 PRACTICE / PROCEDURE

5.1 Safety Event – A safety event is any variance not consistent with the desired, normal, or usual operations of the organization. Safety events can involve patients, employees, visitors or others. An injury does not have to occur.

5.2 Practice for all employees includes:

- Report a safety even as soon as the event has been discovered after taking appropriate immediate action.
- Formal reporting will be done using Online Redform Risk Reporting (create link).
- Safety event reporting is expected to occur the day the event occurred or was detected to assure accurate recall of the circumstances and facts surrounding the incident.
- If an employee believes he or she has been subjected to inappropriate punitive measures as a result of self-disclosure, the individual should report it to their department leadership, if appropriate, or to Human Resources.

5.2 Expectation of staff:

- Avoid causing unjustified risk or harm. (e.g. physical, financial, reputation, privacy, emotional) Look for the risks and hazards around you.
- Report errors and hazards (speak up)
- Help to design safe systems
- Manage safe choices:
 - Follow procedures
 - Make choices aligned with organizational values

5.3 Practice for managers:

All leadership shall take proactive measures to assure their employees that the System's culture promotes full disclosure of safety events. Such events will be handled consistently with the System's philosophy of responding with a focus on process, prevention and process improvement measures (versus punitive actions).

Upon formal notification of a safety event, operational leadership associated with the event will begin an investigation process to identify the type of behavior that led to the safety event. These three behaviors/actions are:

1. Human Error- slip lapse or mistake; unintended error and a product of a current system design that often fails to consider the impact of the human factor.
 2. At-Risk- A choice: risk not recognized, risk of deviation deemed minimal or believed justified.
 3. Reckless- Intentional risk taking; knows risk associated with action but consciously disregards risk.
- (See Appendix A, Guidelines for Analyzing and Responding to a Safety Event).

5.4 Expectations for managers:

- Knowing the risk
 - Investigating the source of errors and at-risk behaviors
 - Turning events into an understanding of risk
- Designing safe systems
- Facilitating safe choices focused on managing behaviors:
 - Human Error – Consoling (e.g. providing emotional support, EAP and/or crisis management team appropriate to the situation)
 - At-Risk – Coaching (e.g. education, review of applicable standards, manage incentives)
 - Reckless – Corrective Action

Managers will follow Corrective Action policy for Reckless Behaviors including:

- Reckless disregard of the procedural risks associated with noncompliance.
- Reckless disregard toward harm to self or others OR
- When remedial action (e.g. education, coaching) is not effective in changing behavior

Assistance

To further assist in the appropriate evaluation of these individual behaviors/actions, Human Resources and clinical quality and safety leaders are available to coach managers using the Just Culture Algorithm. The Just Culture Algorithm is a tool intended to aid in determining the right course of action when an employee has made an error, drifted into an at-risk behavior, or has otherwise not met his obligations to the organization. Use of the algorithm is optional and intended for use by those who have had additional training in the tool. (See Appendix B, HFHS Just Culture Algorithm)

In accordance with applicable significant event or risk management guidelines, managers, senior leaders and other healthcare team members may be notified depending on the severity of the concern or event.

Attachments to Patient Safety HR Policy 5.24:

Appendix A: Guideline for Analyzing and Responding to a Safety Event
Appendix B: HFHS Just Culture Algorithm

See also HFHS related policies or links:

Compliance Reporting, Investigation and Remediation Process C-005
Confidentiality and Information Security Policy 5.18
Corrective Action Program Policy 5.17
Drug-Free Workplace Policy 5.11
Electronic Business Communications Policy 5.21
Health Professional Licensing and Disciplinary Reform Act 4.08
Performance Improvement Program Policy 5.10
RadicalLogic Online Redform: Risk – Reporting of Safety Events I.E.6
Sentinel Events and Critical Incidents 600.00
Whistleblower’s Protection Act Policy 4.12

REFERENCES:

Connor M., et al.: Creating a fair and just culture: One institution's path toward organizational change. *The Joint Commission Journal on Quality and Patient Safety* 33:10, 617-624, October 2007.

Frankel A., et al.: Improving patient safety across a large integrated health care delivery system. *Int J Qual Health Care* 15 (suppl. 1):i31-i40, De. 2003.

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

Just culture training for healthcare managers. *The Just Culture Community*. 10 June. 2008 <<http://www.justculture.org>.

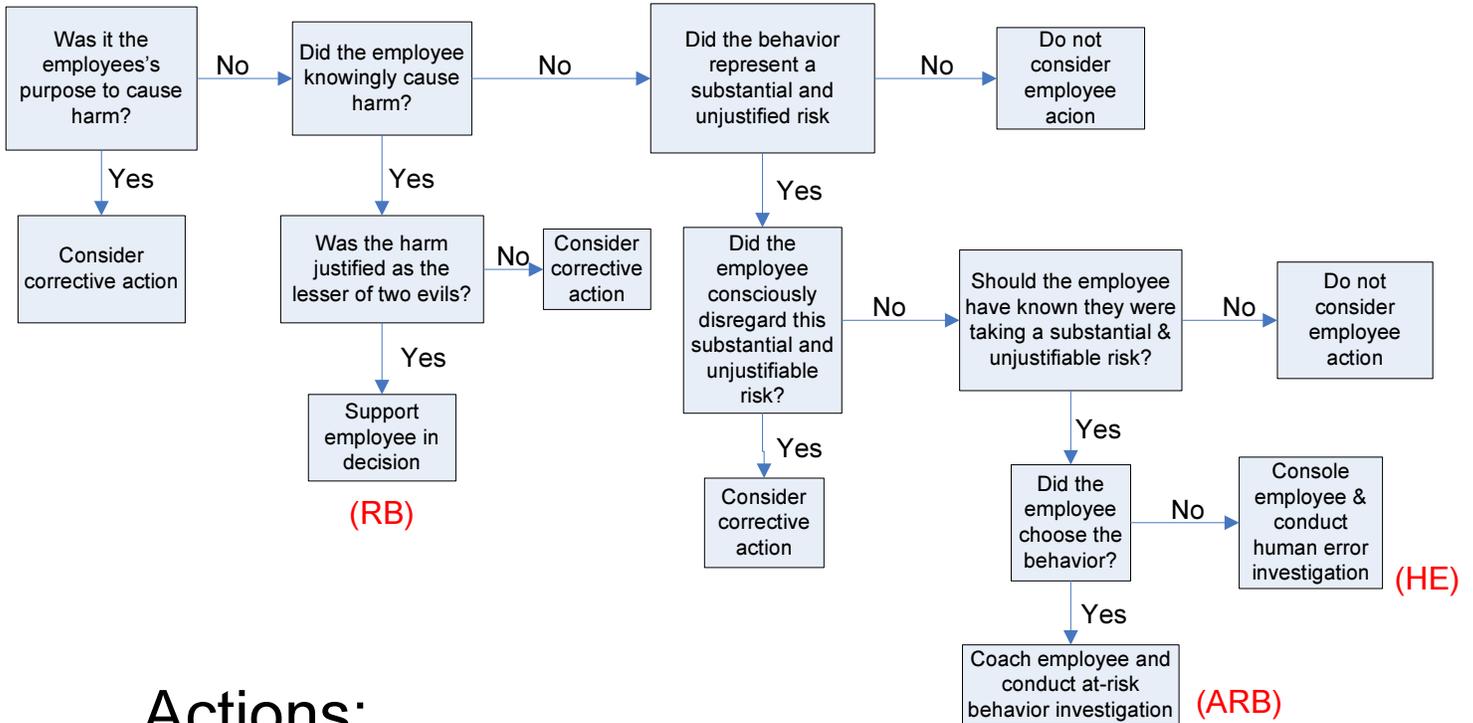
Marx D.: *Patient Safety and the "Just Culture": A Primer for Health Care Executives*. New York City: Columbia University, 2001.

Appendix A: **Guideline for Analyzing and Responding to a Safety Event**

Behavior / Actions Classification	Human Error	At-Risk Behavior	Reckless Behavior
Definition	Inadvertent action: lapse, mistake	A choice: risk not recognized or believed justified	Conscious disregard of unreasonable risk (Note: Repetitive at-risk behaviors may become reckless but manager must rule out system’s contribution to the repetitive behaviors)
Manage through:	Changes in: <ul style="list-style-type: none"> • Processes • Procedures • Training • Design • Environment 	<ul style="list-style-type: none"> • Remove incentives for at-risk behavior • Create incentives for healthy behaviors • Increase awareness of risks involved (situational awareness) 	Follow Corrective Action Program Policy: HR Policy 5.17
*NOTE: OUTCOMES DO NOT PREDICATE HOW WE MANAGE BEHAVIORS			
Response	Console the person who committed human error. These errors should be seen as a product of the system in which the employee works. The systems are what have to be corrected. Managers, supported by leadership should identify and change error-prone processes, procedures and environments (since managers are responsible for the environment in which employees work.)	Coach non-punitively. Identify, manage and coach at-risk behaviors proactively.	Corrective Action Follow Corrective Action Program Policy (HR Policy 5.17)
Examples of Actions/Behaviors	<p>Physician orders 100 mg of drug instead of 10 mg.</p> <p>RN is constantly interrupted during medication administration to attend to patients needs.</p> <p>New RN programs pump incorrectly because of inadequate orientation to pump and lack of availability of preceptor.</p> <p>A patient transporter misinterprets a location code and delivers a patient to OR instead of Interventional Radiology</p>	<p>RN labels blood specimen at nursing station rather than at bedside because she has never heard of or been involved in a mislabeling incident.</p> <p>Technician does not check 2 patient identifiers and labels x-rays with wrong name.</p> <p>A housekeeper brings bleach from home and places it in her mop water in hopes of providing better cleaning and a fresher smell. She is assigned to clean up a spill of formaldehyde which has an adverse chemical reaction to the bleach in her mop water.</p>	<p>Professional provides patient care while intoxicated.</p> <p>Prior to administering blood, RN falsifies a second RN signature in violation of requirement for double check prior to blood transfusion.</p> <p>Physician has been reminded repeatedly regarding personal safe practices regarding hand washing but does not wash hands prior to examining patient.</p> <p>An office employee passes sensitive patient information about a celebrity to the local newspaper, in strict violation of hospital policy.</p>



Just Culture Algorithm The Duty to Avoid Causing Unjustifiable Risk or Harm



Actions:

With System	With Employee
-------------	---------------

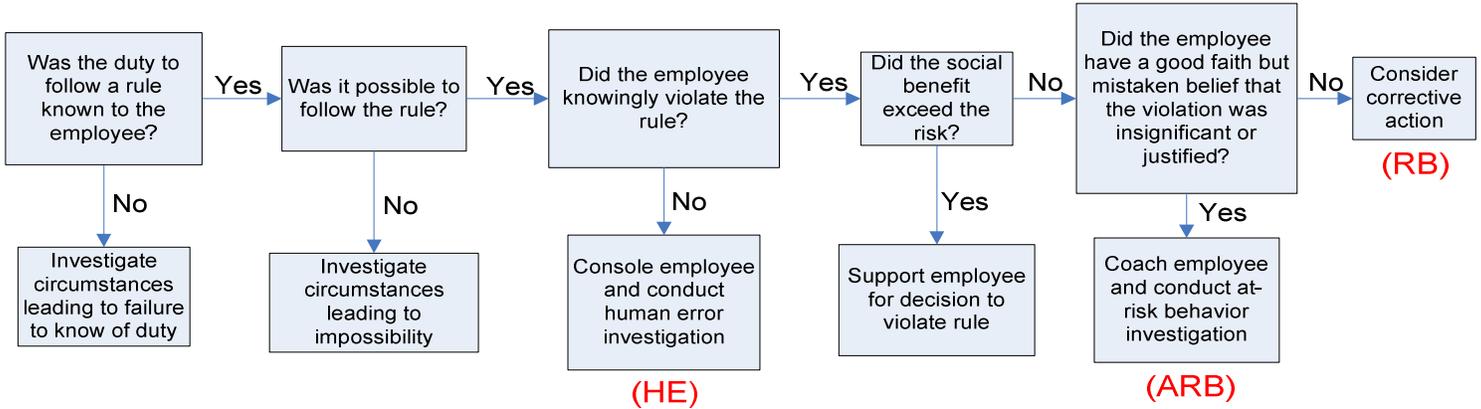
Human Error (HE)	Modify system performance shaping factors	Console employee Remedial action
At-Risk Behavior (ARB)	Modify system performance shaping factors	Coach employee Remedial action
Reckless Behavior (RB)	Modify system performance shaping factors	Corrective action Remedial action

At all times, an employee will be subject to the duty to avoid causing unjustifiable risk or harm to himself, to fellow employees, customers, visitors, and to the organization. Under this duty An employee will be subject to disciplinary action when they have acted with reckless disregard toward the potential harm to themselves or others.



Just Culture Algorithm The Duty to Follow a Procedural Rule

(System largely controlled by the employer)



Actions:

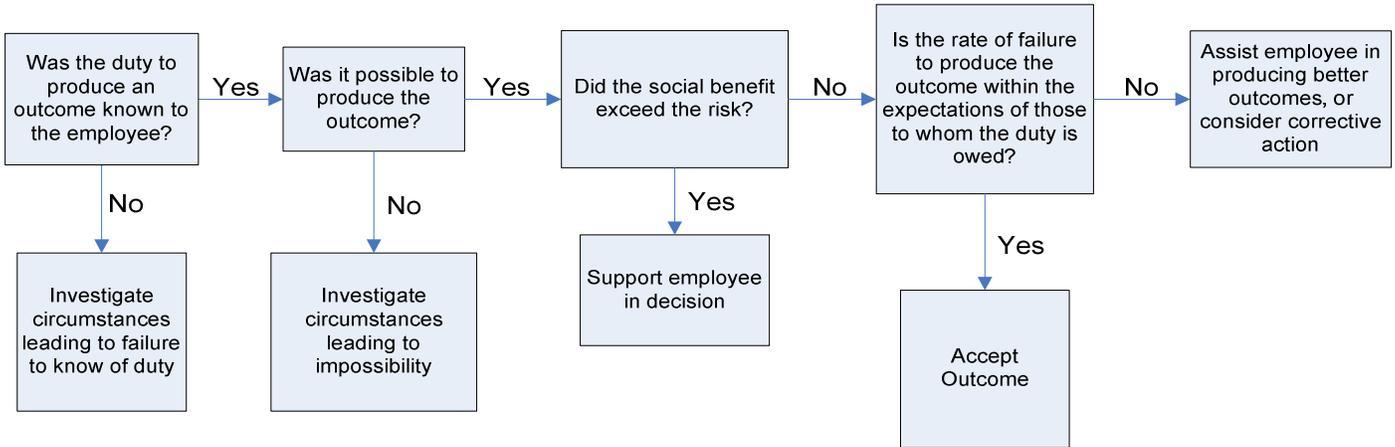
	With System	With Employee
Human Error (HE)	Modify system performance shaping factors	Console employee Remedial action
At-Risk Behavior (ARB)	Modify system performance shaping factors	Coach employee Remedial action
Reckless Behavior (RB)		Corrective action Remedial action

Where working under a duty to follow a procedural rule within a system, an employee will be subject to disciplinary action when they have acted with reckless disregard toward the risk associated with non-compliance.



Just Culture Algorithm The Duty to Produce an Outcome

(System largely controlled by the employee)



Actions:

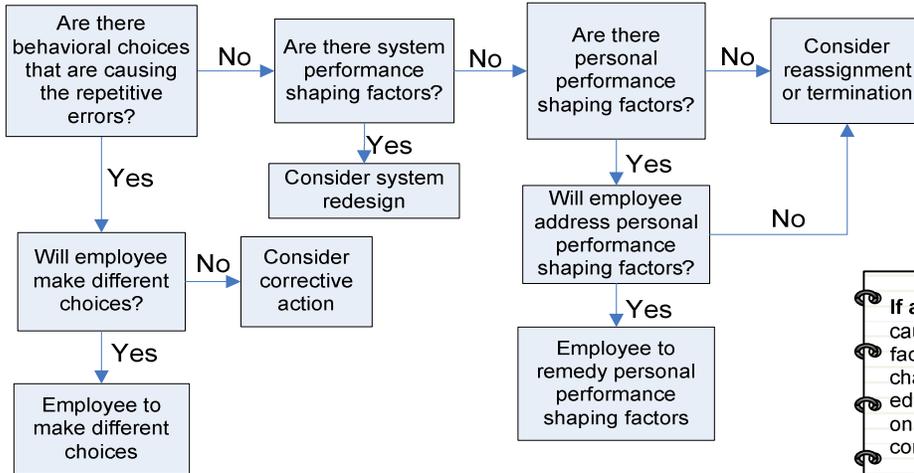
	With System	With Employee
Duty to Produce Outcome	Modify system performance shaping factors	Help employee produce better outcomes Corrective action

Where working under a duty to produce an outcome, an employee will be held accountable as directed by the code of conduct and individual policies. These policies put the employee on notice to the duty, and prescribe acceptable outcomes attached to each duty (e.g. time and attendance, dress code, harassment).

Just Culture Algorithm Repetitive Behaviors



Repetitive Human Errors:

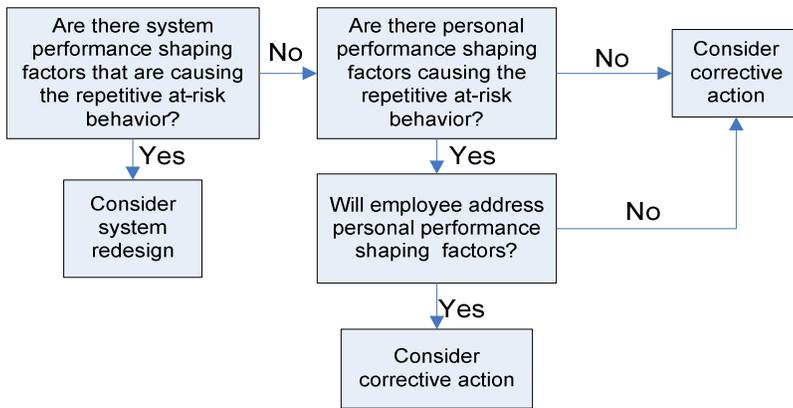


Actions:

	With System	With Employee
Duty to produce outcome	Modify system performance shaping factors	Employee to address performance shaping factors Employee to make better behavioral choices

If a series of human errors is not caused by system performance shaping factors, and is not correctable by changes in work choices or remedial education/training, the employee is put on notice that further errors may result in corrective action

Repetitive At-Risk Behaviors:



Actions:

	With System	With Employee
Repetitive At-Risk Behaviors	Modify system performance shaping factors	Employee to address performance shaping factors Employee to make better behavioral choices

If a series of at-risk behaviors is not caused by system performance shaping factors, and the employee has not been responsive to behavioral coaching, the employee is put on notice that further at-Risk behaviors may result in disciplinary Action.

Definitions:

AT-RISK BEHAVIOR – behavioral choice where risk is not recognized, or is mistakenly believed to be justified

COACHING – supportive discussion with the employee on the need to engage in safe behavioral choices

COUNSELING – a first step disciplinary action; putting the employee on notice that performance is unacceptable

DISCIPLINARY ACTION – actions beyond remedial, up to and including punitive action or termination

HUMAN ERROR – inadvertently doing other than what should have been done: a slip, lapse, mistake

IMPOSSIBILITY – condition outside of employee’s control that prevents duty from being fulfilled

KNOWINGLY – having knowledge that harm is practically certain to occur

PERFORMANCE SHAPING FACTORS – Attributes that impact the likelihood of human errors or behavioral drift

PUNITIVE ACTION – punitive deterrent to cause an individual or group to refrain from undesired behavioral choices

PURPOSE – conscious objective to cause harm

RECKLESS BEHAVIOR – behavioral choice to consciously disregard a substantial and unjustifiable risk

REMEDIAL ACTION – actions taken to aid employee including education, training, assignment to task appropriate to knowledge and skill

SUBSTANTIAL AND UNJUSTIFIABLE RISK – A behavior where the risk of harm outweighs the social benefit attached to the behavior