Rady Children's Hospital San Diego	CURRENT EFFECTIVE DATE **January 2012**	REVISED DATE **September 2011**	MANUAL: **Personnel**
			TRACKING # **PPM 826**
☐ **P O L I C Y/PROCEDURE** ☐ **STANDARDIZED PROCEDURE** ☐ **PLAN** ☒ **GUIDELINE**	TITLE: **RCHSD COMMITMENT TO QUALITY, SAFETY, AND JUST CULTURE GUIDELINES**		
	PERFORMED BY: **All RCHSD Staff**		

Specialty Review		**Council Review**	**ACCREDITATION/STANDARD**
☐ Human Resources ☐ EOC/Safety ☐ Med Staff ☐ Risk Management ☐ Forms	☐ Information Management ☐ Infection Control ☐ Interdisciplinary Practice ☐ Pharmacy & Therapeutics ☐ Compliance	☐ Center Review ☐ Med Staff Executive ☐ Clinical Review ☐ EOC/Safety	

1.0 PURPOSE:

- To provide a structured, consistent process for leaders to use when following up with staff on safety concerns.
- To foster a learning culture with increased reporting, transparency and accountability

2.0 PHILOSOPHY:

In order to support and deliver safe and effective care, RCHSD commits to the following:

- Accountability belongs to the individual *and* our system. People are accountable for their own actions but should not carry the burden for system flaws.
- Effective teamwork and open communication foster an environment that reduces errors.
- We strive to standardize and simplify information so that everyone shares a common understanding.

We will use what we learn to make changes that improve safety.

- We commit to looking for and correcting the causes of adverse events, assigning responsibility for implementing actions to specific individuals or groups.

We promote open discussion within our organization to learn about adverse events and potential causes of patient harm.

- We commit to developing and maintaining easy and effective ways for caregivers and patients to discuss adverse events and safety concerns.

- We encourage sharing what we learn; this information helps lead us to actions that improve the healthcare environment.

We promote interdisciplinary discussion to analyze adverse events and potential patient harm.

- We will seek different points of view to identify sources of patient harm.
- We believe that patient/family input is indispensable to the delivery of safe care, and we commit to promoting patient/family participation in our organizational decisions.
- We commit to unbiased analysis of incidents of patient harm or potential harm, looking at both the system and individual factors.

We will inform patients and families, caregivers, leadership, and trustees about actions taken to improve patient safety.

- We commit to fostering an environment that is concerned with safety through ongoing education, reminders and dialogue.
- We commit to ensuring that our leaders and caregivers understand the complexities of delivering safe patient care and support our commitment to a safe and just culture.

We will measure our success in promoting an environment of patient safety.

3.0 DEFINITIONS

3.1 **Human Error** – Inadvertently doing other than what should have been done; a slip, lapse, mistake

3.2 **At-Risk Behavior** – A behavior choice that increases risk where risk is not recognized, or is mistakenly believed to be justified

3.3 **Health Issue/Possible Reckless Behavior** – A health condition that increases risk where risk is not recognized or a conscious decision has been made to disregard substantial and unjustifiable risk of causing harm

3.4 **Reckless Behavior** – Conscious decision to disregard substantial and unjustifiable risk of causing harm

3.5 **Red Rule** – Requirements that are considered so important to an organization that there is no tolerance for their being broken. Except in rare or urgent situations, Red Rules are used to identify standards that should be undertaken every time a particular event or process occurs. Because of their importance, when a Red Rule is broken, it is considered Reckless Behavior, regardless of the intended consequences or outcome.

3.6 **Systems Issues** - Unintended organizational breakdown or failure of interacting components (people, processes, equipment, environment) which contributes to undesirable results

3.7 **Support** –A learning conversation discussing why an event happened and what, if anything, can be done to prevent it from happening again. Also involves comforting the employee in an attempt to alleviate the grief, sense of loss and/or anxiety they may be feeling.

3.8 **Coaching** – A learning discussion in response to an at-risk behavior; often involves raising awareness and/or changing the perception of risk and establishing an understanding of the consequences. The purpose of coaching can be to improve performance, often by eliminating, mitigating or reducing risk.

3.9 **Corrective Action** - Documented action plan designed to specifically address areas of required improvement in performance. Corrective Action may be progressive in

nature or may lead to disciplinary action up to termination depending upon the severity of the infraction.

3.10 **Systems Analysis** – A comprehensive and structured approach intended to evaluate the interplay of an individual and the design of protocols, processes, procedures, training, and environment for the purpose of improving reliability. Correction of systems issues may include mitigating human errors, removing opportunities for at risk behavior, creating incentives for healthy behaviors, and increasing situational awareness.

4.0 PROCEDURE:

The Just Culture Algorithm is a guide to assist in event analysis and action planning by the appropriate Manager/Director, in conjunction with Human Resources. This excludes those incidents which involve violation of State and Federal law and RCHSD Standards of Conduct.

EVENT ANALYSIS:

- After an incident involving a staff member occurs, follow the Just Culture algorithm path by answering the specific algorithm question and moving to the next question based on the answer arrow.
- Real world situations are rarely able to be answered with a simple yes/no. The supplemental questions included below are designed to aid you in your analysis.
- If you are asking questions of a member of a collective bargaining unit work with your Human Resource Partner to offer the employee the opportunity for union representation.
- The analysis begins with the Deliberate Harm Test on the Just Culture Algorithm.

4.1 **Deliberate Harm Test: Was it the employee's deliberate intent to cause harm?**

- Specific Intent: To identify if the employee made the choice to behave as he/she did to cause or potentially cause a negative outcome.
- Supplemental Questions:
  - Were the actions purposeful/a choice?
  - What was the intent?
  - How do we know this was the intent?
  - Why would this person have this intent at this time?
  - Who else knew about this intent?
  - When/where was this intent expressed?
  - Why is this intent important?
  - Was the employee aware of the risks posed by their actions?

4.2 **Incapacity Test: Does the person appear to be ill, under the influence, or unfit for duty?**

- Specific Intent: To identify if the employee has reported to work in a condition that poses a safety risk to themselves or others or has engaged in conduct that detracts from the effective and efficient operations of RCHSD.
- Supplemental Questions:

- What specific behaviors are being exhibited?
- How often?
- Who else has seen the behavior?
- Are there multiple causal possibilities for the behaviors?
- Are there performance issues?
- Have the performance issues been addressed? When, by whom and how?
- Has the person expressed a need for any ADA qualifying help?

4.3 **Foresight Test: Did the person follow relevant policies, procedures, and standards of care?**

- Specific Intent: To identify whether protocols and safe working practices were adhered to.
- Supplemental Questions:
  - What specific policy, procedure or standard of care was violated?
  - Why were the policies, procedures and standards of care not followed?
  - How do we know they were not followed?

4.4 **Red Rules Test: Violation of RCHSD Red Rule?**

- Current RCHSD Red Rules include:
  1) Privacy policies
  2) Child Safety-related policies
  3) Patient Identification Verification

4.5 **Substitution Test: Are other individuals (in the same peer group with similar qualifications & experience) exhibiting or vulnerable to this same behavior/action?**

- Specific Intent: To identify issues that may exists amongst the group, unit, department or organization. To assess how a peer may act with the same situation to identify vulnerabilities beyond the individual.
- Supplemental Questions:
  - Were there any deficiencies in training, experience or supervision?
  - How prevalent is this behavior amongst the employee's peers?
  - What normally happens? Could involve having other employees take you through the steps they follow when performing same task.
  - Were there mitigating circumstances that lead to the individual's action?
    - If not, why would they not?
    - If yes, why would this be true?
    - If yes, what are the circumstances that would make this true?

4.6 **Foresight Test: Are the policies, procedures, AND systems: available, workable, intelligible, up-to-date, routinely used, AND sufficient to manage risk?**

- Specific Intent: To identify systems, policies, process, or procedural vulnerabilities. To identify organization policies that are not feasible to adhere to.
- Supplemental Questions:
  - Was the employee aware of the policy/procedure?
  - Was the employee educated on the policy/procedure?

- Did the individual have ready access to the policy/procedure?
- Are there any conflicting policies/procedures?
- Was it possible to follow the policy/procedure?
- Policy/procedure technically accurate but not feasible for applying in the work setting?
- Did the policy/procedure promote correct and sensible action?
- Was the policy/procedure recently changed?
- Does the source of the series of human errors or at-risk behaviors reside within the system?
- Does the system rely on employee vigilance to not make a mistake?
- How was the risk being managed before this event?
- Are barriers in place to prevent this incident from reoccurring?

4.7 **Repetitive Error Test: Is this a repetitive error?**

- Specific Intent: To identify individuals who have a history of the same or similar behavior/actions.
- Supplemental Questions:
  - Is the individual repetitively violating policy or involved in unsafe acts
  - Does the individual have a history of errors or mistakes?
  - Are there unidentified physical causes that are leading to these repetitive actions or behaviors?
  - What types of mistakes or violations has this employee made in the past? How often?
  - Has there been past support, education, or coaching? With whom and when?
  - Is there documentation of past support, education, or coaching with this employee?

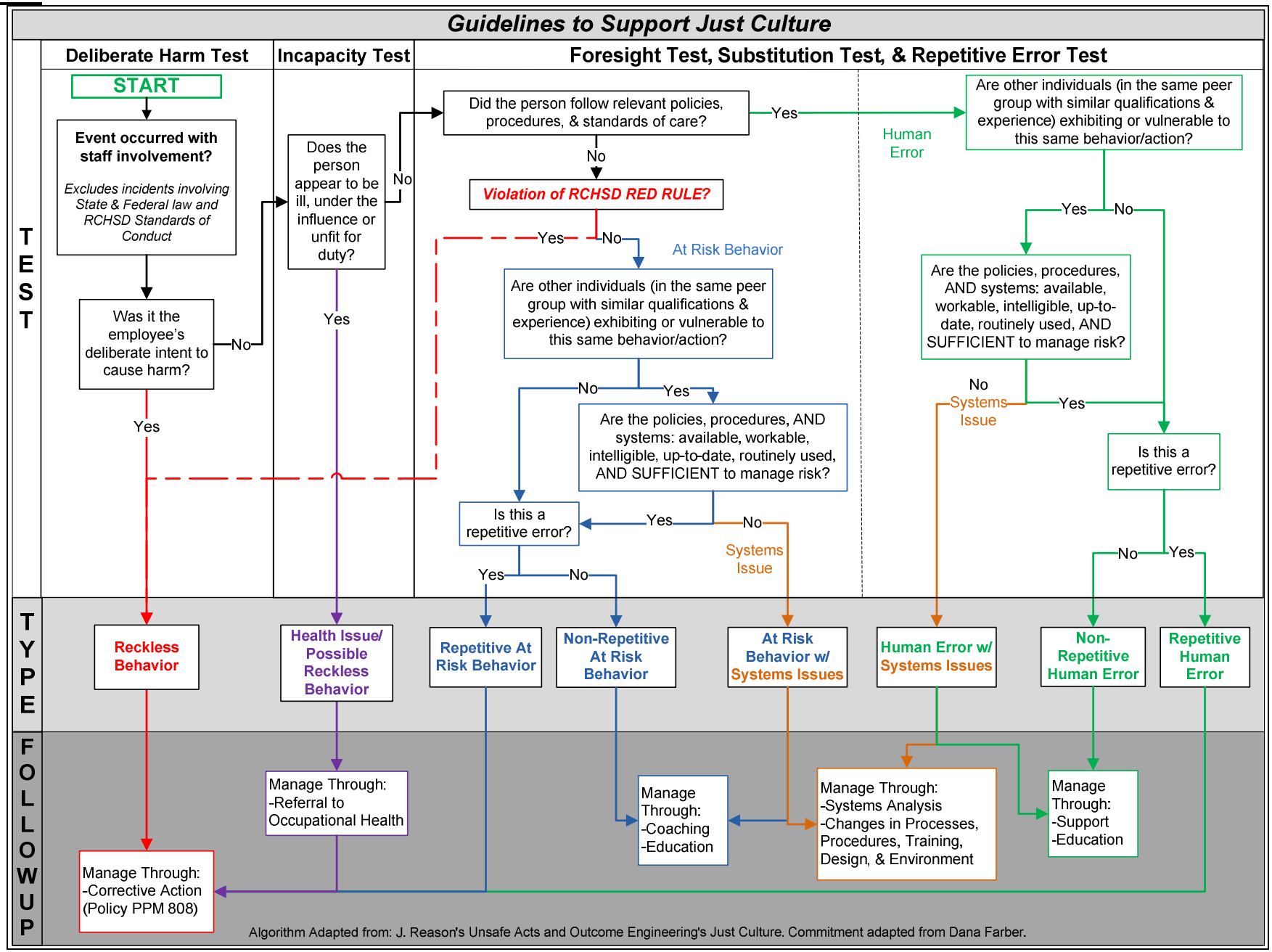
5.0 CROSS REFERENCES:

5.1 CPM 9-03: Safety Reporting System
5.2 CPM ####: Second Set of Eyes Policy
5.3 CPM 12-24: Privacy Violation Investigation, Sanction, and Corrective Action Protocol
5.4 PPM 808: Corrective/Disciplinary Actions
5.5 CPM 12-21: Code of Conduct

6.0 APPENDIX

Just Culture Follow-up		
Event Classification	**Staff Follow-up**	**Organizational Contacts & Resources**
Reckless Behavior	Corrective Action	Human Resources Department Leadership
Red Rules Violation	Corrective Action	Privacy: Health Information Department Second Set of Eyes: Child Safety Task Force Human Resources Department Leadership
Health Issue/Possible Reckless Behavior	Referral to Occupational Health	Occupational Health Human Resources Department Leadership
Repetitive At Risk Behavior	Corrective Action	Human Resources Department Leadership
Non-Repetitive At Risk Behavior	Coaching Education	Department Leadership
At Risk Behavior with Systems Issues	Coaching Education	Department Leadership Unit or Organization Systems Analysis (Industrial Engineering Department, Procedure Council, Education Council)
Repetitive Human Error	Corrective Action	Human Resources Department Leadership Occupational Health
Human Error with Systems Issues	Support Education	Department Leadership Unit or Organization Systems Analysis (Industrial Engineering Department, Procedure Council, Education Council)
Non-Repetitive Human Error	Support Education	Department Leadership

7.0 APPENDIX


Guidelines to Support Just Culture
Deliberate Harm Test
Incapacity Test
Foresight Test, Substitution Test, & Repetitive Error Test
TEST
START
Event occurred with staff involvement?
Excludes incidents involving State & Federal law and RCHSD Standards of Conduct
Was it the employee's deliberate intent to cause harm?
No
Yes
Does the person appear to be ill, under the influence or unfit for duty?
No
Yes
Did the person follow relevant policies, procedures, & standards of care?
Yes
No
Violation of RCHSD RED RULE?
Yes
No
At Risk Behavior
Are other individuals (in the same peer group with similar qualifications & experience) exhibiting or vulnerable to this same behavior/action?
No
Yes
Are the policies, procedures, AND systems: available, workable, intelligible, up-to-date, routinely used, AND SUFFICIENT to manage risk?
Yes
No
Systems Issue
Is this a repetitive error?
Yes
No
Human Error
Are other individuals (in the same peer group with similar qualifications & experience) exhibiting or vulnerable to this same behavior/action?
Yes
No
Are the policies, procedures, AND systems: available, workable, intelligible, up-to-date, routinely used, AND SUFFICIENT to manage risk?
No
Systems Issue
Yes
Is this a repetitive error?
No
Yes
TYPE
Reckless Behavior
Health Issue/ Possible Reckless Behavior
Repetitive At Risk Behavior
Non-Repetitive At Risk Behavior
At Risk Behavior w/ Systems Issues
Human Error w/ Systems Issues
Non-Repetitive Human Error
Repetitive Human Error
FOLLOWUP
Manage Through: -Corrective Action (Policy PPM 808)
Manage Through: -Referral to Occupational Health
Manage Through: -Coaching -Education
Manage Through: -Systems Analysis -Changes in Processes, Procedures, Training, Design, & Environment
Manage Through: -Support -Education
Algorithm Adapted from: J. Reason's Unsafe Acts and Outcome Engineering's Just Culture. Commitment adapted from Dana Farber.