TITLE: JUST AND ACCOUNTABLE CULTURE

PURPOSE: To establish processes and procedures to support a Just Culture environment.

POLICY STATEMENT:

Harris Health System (Harris Health) operates within a Just and Accountable Culture (JAC) using a consistent, fair and systematic approach to managing behaviors to facilitate a culture that balances a non-punitive learning environment with the equally important need to hold persons accountable for their actions.

POLICY ELABORATIONS:

This policy applies to all Harris Health Workforce members.

All Workforce members shall be encouraged to speak-up, speak-out, and feel safe about reporting of Safety Events, existence of hazardous conditions, Human Errors, and related opportunities for improvement, as a means to identify system and behavior changes necessary to mitigate or prevent future events.

Harris Health recognizes that employees must balance personal and organizational values with:

1. The duty to avoid causing unnecessary risk or harm;
2. The duty to produce an outcome; and
3. The duty to follow a procedural rule.

I. DEFINITIONS:

A. **ACCOUNTABILITY:** The obligation of an individual or organization to accept responsibility for their decisions and behaviors, and to disclose the results in a transparent manner.

B. **BEHAVIORAL CHOICES:** Behavioral Choices are defined as the following:

1. **HUMAN ERROR:** Inadvertently doing other than what should have been done: a slip, lapse, mistake, inadvertent action.
2. **AT-RISK BEHAVIOR:** Behavioral choice where risk is not recognized, or is mistakenly believed to be justified: Unintentional risk taking, Believing the risk to be justified.

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3. **RECKLESS BEHAVIOR:** Behavioral choice to consciously disregard a substantial and unjustifiable risk: Choosing an action that knowingly puts people in harm's way.

C. **JUST CULTURE:** A culture that recognizes:

1. Competent professionals make mistakes and develop unhealthy norms;
2. The ability to recognize that errors may result from system factors;
3. Individuals should not be treated punitively for system defects and promotes an atmosphere where Workforce members can freely discuss Safety Events without the fear of reprisal, through an objective assessment of events, which in turn promotes system modifications; and
4. Reckless Behavior, gross misconduct, or willful violations will not be tolerated.

D. **LEADERSHIP:** For the purposes of this policy shall include the governing body, senior leaders (supervisor level and above), and leaders of the Harris Health Medical Staff.

E. **SAFETY EVENT:** Any variance not consistent with the desired, normal, or usual operations of the organization. Safety Events can involve patients, Workforce members, visitors, or others. An injury does not have to occur. Safety Events are defined as the following: (See Harris Health Incident Reporting Policy 3.63).

1. **ADVERSE EVENTS:** A patient care event that is unfavorable, undesirable, and usually unanticipated that causes death or serious injury, or the risk thereof. Adverse Events may result from unintentional acts or omissions.
2. **INCIDENT:** An accident or injury that occurs within Harris Health staffed locations that is inconsistent with the standard of care of a patient or routine operations of Harris Health which may result in an unanticipated harm or injury to patients, visitors, Workforce members.
3. **NEAR MISS:** An event or situation that could have resulted in an accident, injury, or illness, but did not, either by chance or through timely intervention. Near Misses are opportunities for learning and afford the chance to develop preventive strategies and actions. Near Misses will receive the same level of scrutiny as Incidents that result in actual injury.

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4. **SERIOUS REPORTABLE EVENT:** An Incident involving a serious adverse outcome error including death, serious physical or psychological injury or the risk thereof, or other resulting from any process variation for which a recurrence would carry a significant risk of a serious adverse outcome error. Serious injury specifically includes loss of limb or function.

F. **WORKFORCE:** Employees (permanent or temporary), Harris Health Board of Trustees, volunteers, trainees, medical staff, and other persons whose conduct, in the performance of work for Harris Health, is under the direct control of Harris Health, whether or not they are paid by Harris Health.

II. GENERAL PROVISIONS:

A. JAC:

1. The overarching goal of the JAC is to promote and facilitate an organizational culture of open communication, transparency, Accountability, and learning.
2. Overall success of a JAC will result in a cultural transformation that demonstrates the following:

   a. Harris Health Workforce members can articulate the meaning and value of a Just and Accountable Culture;
   b. Workforce members have the ability to freely report safety concerns without fear of retribution;
   c. System process improvements that consist of using a standardized methodology (i.e., tools and processes) for assessing, reviewing, and managing errors are enculturated; and
   d. Increased staff and peer Accountability exists.

B. Harris Health acknowledges Safety Events are not commonly the result of individual Reckless Behavior, but rather system or process defects (Human Error/At-risk Behavior influenced by the system as designed).

IV. PRACTICE / PROCEDURE:

(See Appendix A).

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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 Leaderships. *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

Harris Health System Policy and Procedure 3.63 Incident Reporting

Harris Health System Policy and Procedure 6.09 Introductory Period

Harris Health System Policy and Procedure 6.20 Employee Discipline

OFFICE OF PRIMARY RESPONSIBILITY:

Harris Health System Senior Vice President Human Resources

REVIEW/REVISION HISTORY:

Effective Date	Version # (If Applicable)	Review/ Revision Date (Indicate Reviewed or Revised)	Approved by:
03/14/2017	1.0	Approved. 03/014/2017	Structure and Organizational Standards Committee

APPENDIX A
PROCEDURES AND RESPONSIBILITIES OVERVIEW

I. ALL WORKFORCE MEMBERS RESPONSIBILITIES AND EXPECTATIONS:

A. Responsibilities:

A Workforce member who fails to report or attempts to cover up the occurrence of a Safety Event or Human Error, inadvertently or intentionally shall be subject to disciplinary action, up to and including, termination of employment and reporting to applicable licensing agencies.

1. Report a Safety Event or Human Error as soon as the event has been discovered after taking appropriate immediate action.
2. Formal Safety Event reporting will be done using the Harris Health electronic incident reporting system (eIRS) or using downtime forms when the eIRS is not available.
3. Safety Event and Human Error 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.
4. 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. To further assist in the appropriate evaluation of these individual behaviors/actions, Human Resources and/or Risk Management and Patient Safety Department are available to coach Leadership in using the Performance Management Algorithm. The Performance Management 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 or her obligations to the organization. (See Appendix B, Performance Management Algorithm).

B. Expectation of Workforce Members:

1. Avoid causing unjustified risk or harm (e.g. physical, financial, reputation, privacy, emotional). Look for the risks and hazards around you;

2. Report errors and hazards (speak up);
3. Help to design safe systems; and
4. Manage safe choices:

    a. Follow procedures; and
    b. Make choices aligned with organizational values.

II. LEADERSHIP RESPONSIBILITIES AND EXPECTATIONS:

A. Responsibilities:

1. Harris Health Leadership assures the cultural environment is one which promotes reporting of Safety Events, Human Errors, and that such events will be handled consistently.
2. As part of the normal investigative process for any reportable Safety Event, or Human Error, the Leadership must conduct an investigation to determine the type of behavior that led to the event.
3. All events must be assessed using a systematic approach based on three (3) classifications of behaviors/actions:

    a. Human Error;
    b. At-Risk Behavior; and
    c. Reckless Behavior.

4. All Leadership must proactively assure Workforce members that the System's culture promotes reporting of Safety events and Human Errors and that such events will be handled consistently and fairly.

B. Expectations for Leadership:

1. Upon formal notification of a Safety Event and/or Human Error, Leadership associated with the event will begin an investigation process to identify the type of behavior that led to the event.

2. To further assist in the appropriate evaluation of these individual behaviors/actions, Human Resources and/or Risk Management and Patient Safety Department are available to coach Leadership in using the Performance Management Algorithm. The Performance Management

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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. (See Appendix B, Performance Management Algorithm).

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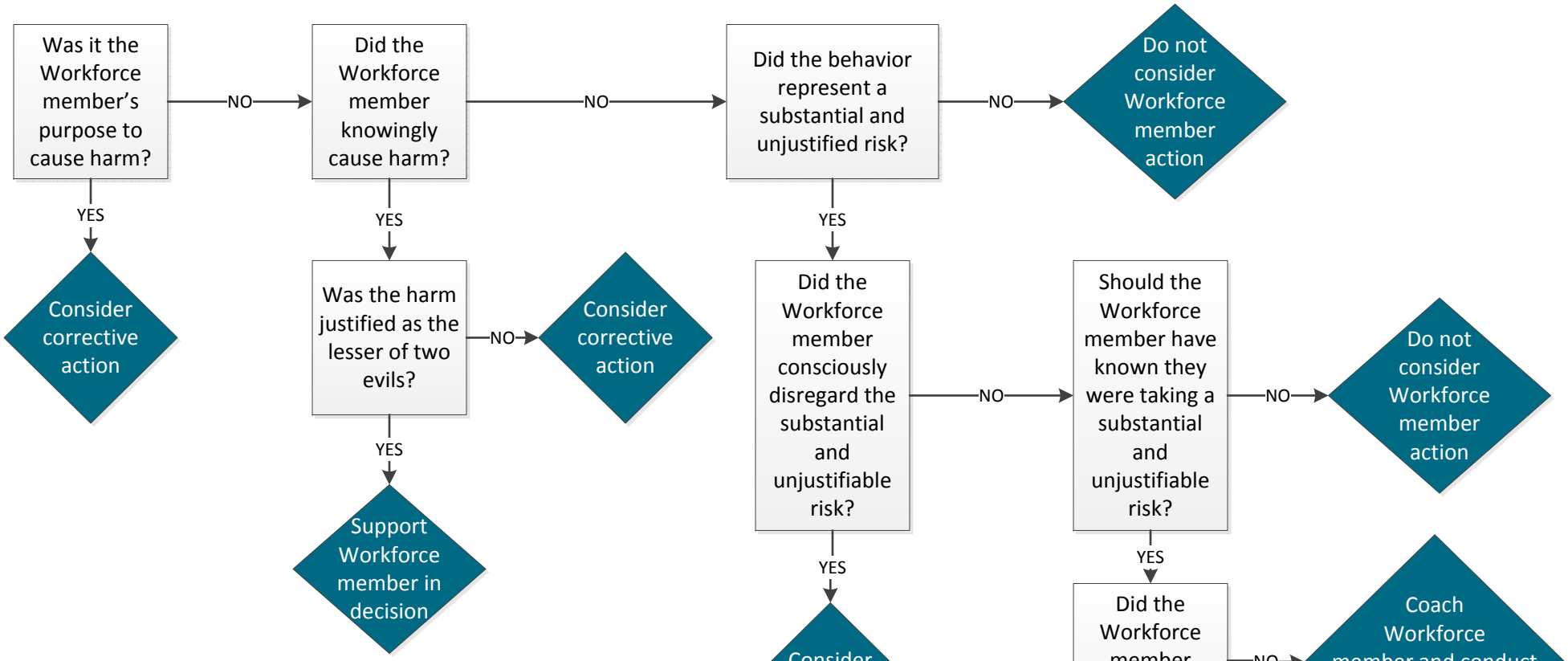
HARRISHEALTH SYSTEM

JAC Algorithm: Duty to Avoid Causing Unjustifiable Risk or Harm



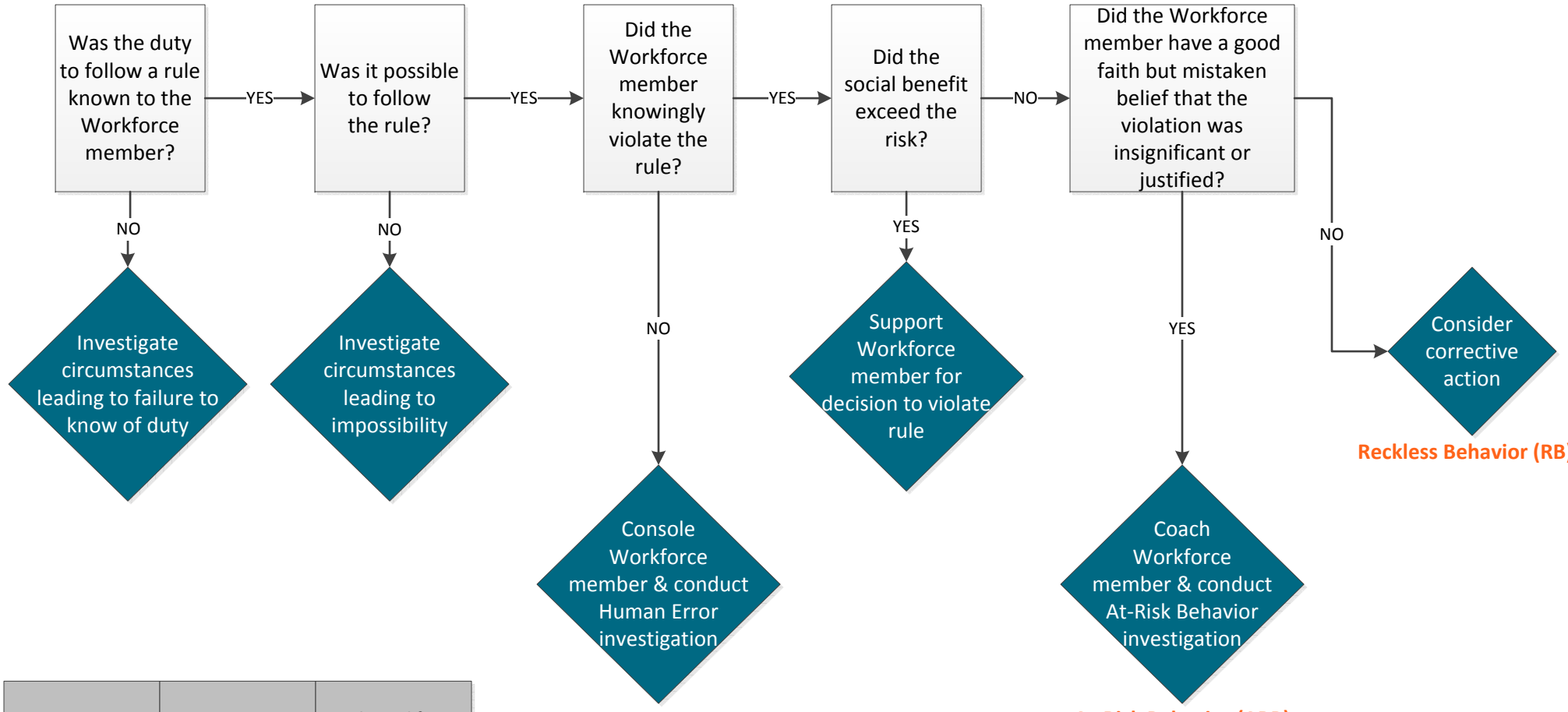
Actions:	With System	With Workforce member
Human Error (HR)	Modify system performance shaping factors	Console Workforce member Remedial action
At-Risk Behavior (ARB)	Modify system performance shaping factors	Coach Workforce member Remedial action
Reckless Behavior (RB)	Modify system performance shaping factors	Corrective action Remedial action

At all times, a Workforce member will be subject to the duty to avoid causing unjustifiable risk or harm to self, other Workforce members, patients, visitors, and to the organization. Under this duty a Workforce member will be subject to disciplinary action when they have acted with reckless disregard toward the potential harm to themselves or others.

Just Accountable Culture

HARRISHEALTH SYSTEM

JAC Algorithm: Duty to Follow a Procedural Rule



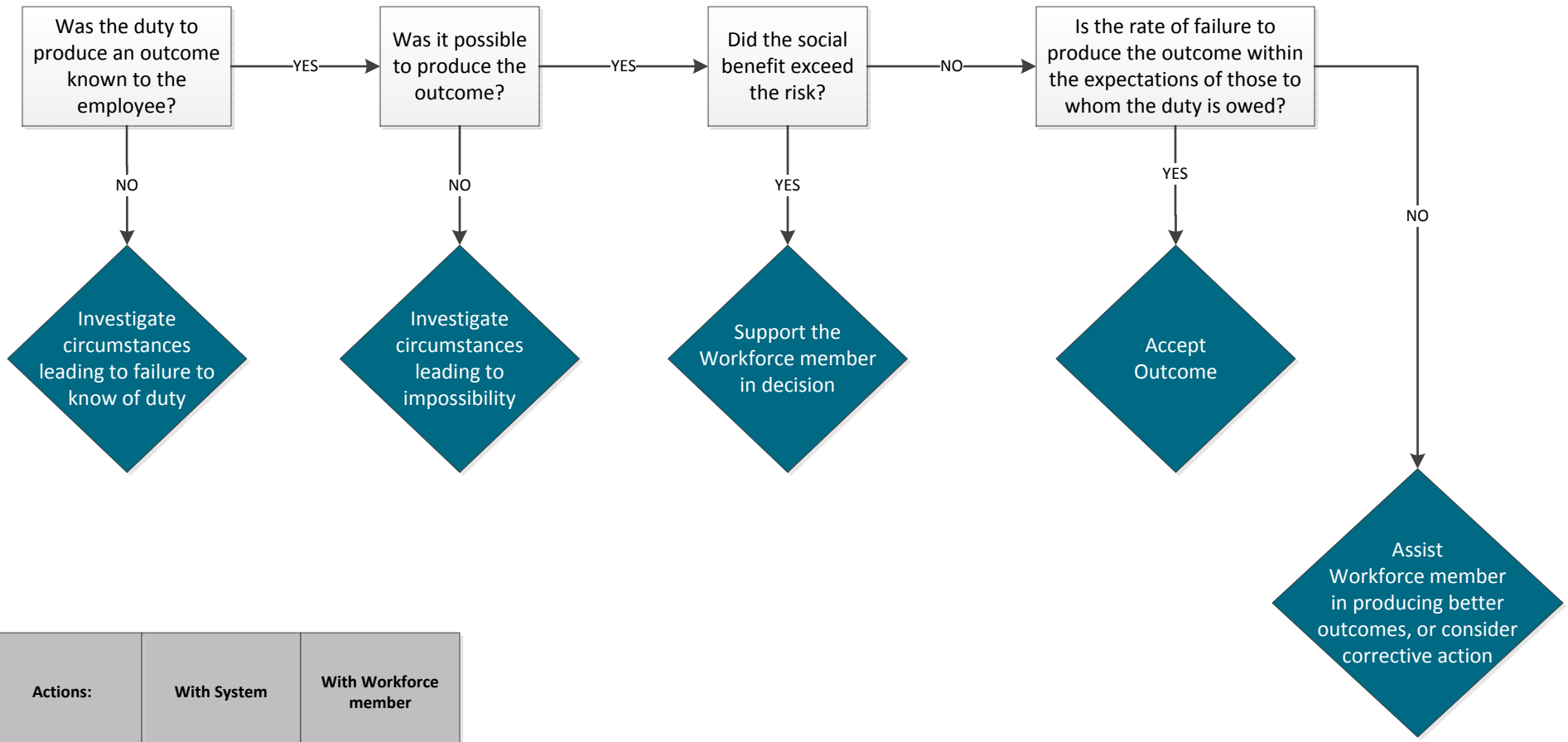
Actions:	With System	With Workforce member
Human Error (HR)	Modify system performance shaping factors	Console Workforce member Remedial action
At-Risk Behavior (ARB)	Modify system performance shaping factors	Coach Workforce member Remedial action
Reckless Behavior (RB)		Corrective action Remedial action

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

Just Accountable Culture

HARRISHEALTH SYSTEM

JAC Algorithm: Duty to Produce an Outcome



Actions:	With System	With Workforce member
Duty to Produce Outcome	Modify system performance shaping factors	Help Workforce member to produce better outcomes Corrective action

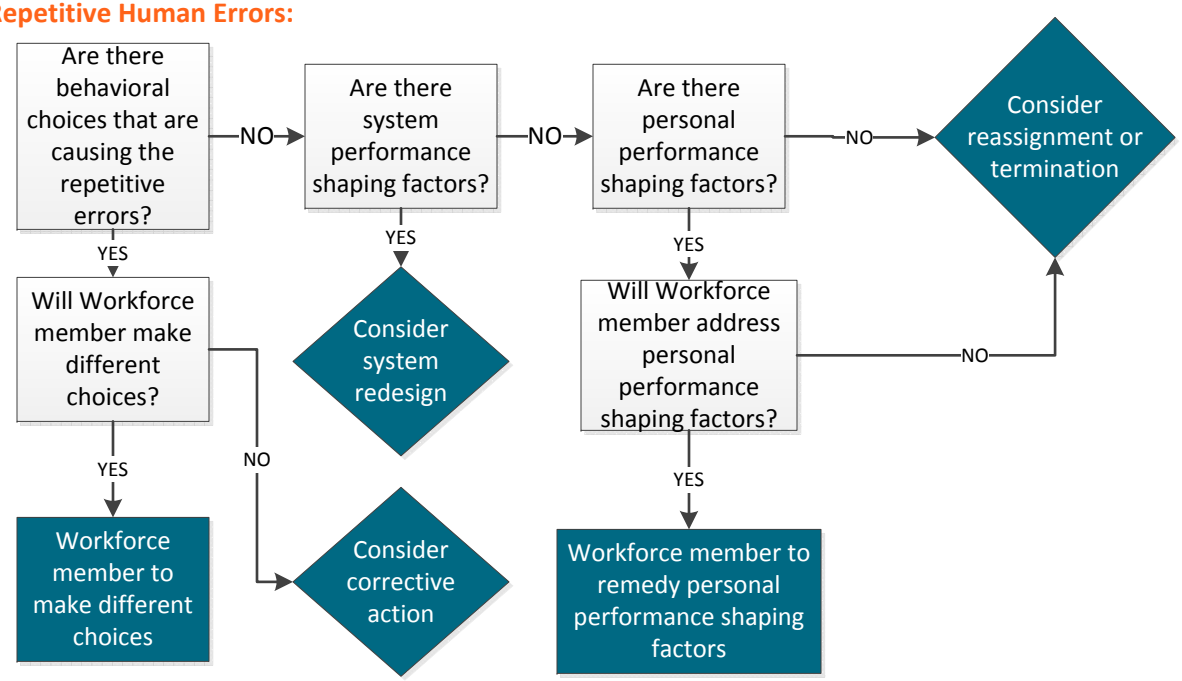
Where working under a duty to produce an outcome, a Workforce member will be held accountable as directed by the code of conduct and individual policies. These policies put the workforce member on notice to the duty and prescribe acceptable outcomes attached to each duty (e.g. time and attendance, dress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

Just Accountable Culture

HARRISHEALTH SYSTEM

JAC Algorithm: Repetitive Behaviors

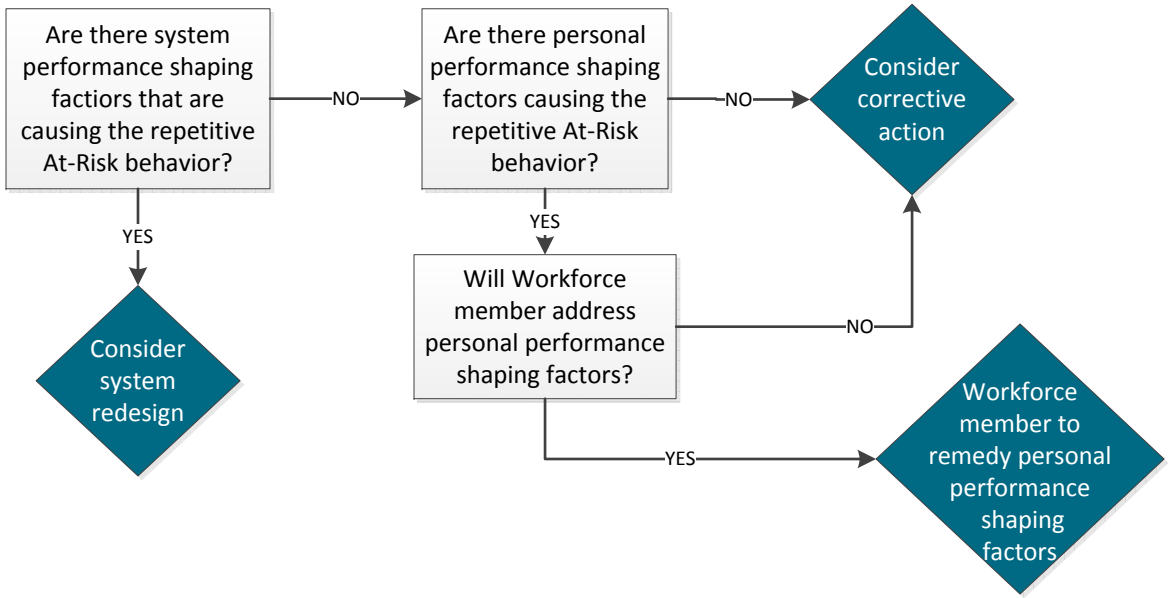
Repetitive Human Errors:



Actions:	With System	With Workforce member
Repetitive Human Errors	Modify system performance shaping factors	Workforce member to address personal performance shaping factors Workforce member 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 Workforce member is put on notice that further errors may result in corrective action.

Repetitive At-Risk Behaviors:



Actions:	With System	With Workforce member
Repetitive At-Risk Behaviors	Modify system performance shaping factors	Workforce member to address personal performance shaping factors Workforce member to make better behavioral choices

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

Just Accountable Culture