

Date: DEC 6 2016

JUST CULTURE

1. **PURPOSE:** Alaska VA Healthcare System (AVAHS) supports a Just Culture that encourages employee self-disclosure and continual delivery of high quality services for patients, employees, and the community it serves. AVAHS 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.

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

- (1) The duty to avoid causing unjustified risk or harm.
- (2) The duty to produce an outcome.
- (3) The duty to follow a procedural rule.

b. To this end, AVAHS employs 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. DEFINITIONS:

a. **Deliberate Harm or Substance Abuse:** A case of malicious, intentional patient harm or substance abuse should be brought to the attention of the facility director and human resources at once. Consideration should also be given to systemic issues, such as whether colleagues had concerns but did not feel safe reporting them, or whether previous patient, family or staff concerns were appropriately investigated.

b. **At-Risk Behavior:** At-risk behavior is used to describe both normal human error and conduct where the individual failed to appreciate the risks created by his or her behavior and is in need of coaching or skill remediation.

c. **Reckless Behavior:** An individual is reckless when he or she takes an action (or chooses not to act) with a knowing and conscious disregard for the risk. Recklessness is morally blameworthy and warrant discipline, regardless of whether harm resulted.

3. POLICY:

a. AVAHS 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).

b. 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.

c. All safety events are to be reported using the procedures outlined in this facility's Patient Safety Reporting Program Policy, Numbered Memorandum 11QM-06.

d. As part of the normal investigative process for any safety event, the Patient Safety Manager will conduct an investigation to determine the type of behavior that led to the safety event to identify simple human/system error.

e. This policy will be followed by managers and leaders in dealing with employee/employees involved in safety events.

4. PROCEDURES:

a. Safety Event:

(1) A safety event is any variance not consistent with the desired, normal, or usual operations of the organization. An injury does not have to occur.

(2) As soon as it is discovered, the safety event will be reported, by the person discovering or witnessing the event, to the facility Patient Safety Manager. Reporting procedures in Numbered Memorandum 11QM-06 will be followed.

b. Expectations: all personnel and volunteers at the AVAHS will:

(1) Avoid causing unjustified risk or harm, e.g., physical, financial, reputation, privacy, emotional.

(2) Report errors and hazards (speak up).

(3) Speak up to prevent an error from occurring.

(4) Help to design safe systems.

(5) Follow procedures and manage safe choices.

(6) Make choices aligned with organizational values.

c. It is expected that managers will reinforce the importance of reporting all patient safety events including those in which no harm occurred or where the incident was avoided by someone speaking up. Managers must be:

(1) Aware of risk: Proactively identifying "At Risk" behaviors.

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(2) Designing safe systems: Identifying workarounds and other safety system bypass issues and taking appropriate actions to identify and address the cause for workarounds.

(3) Responding to employees in the event of:

(a) Human/System Error: Consoling, e.g., providing emotional support, Employee Assistance Program (EAP) and/or crisis management team appropriate to the situation.

(b) At-Risk Behavior: Coaching, e.g., education, review of applicable standards, and manage incentives.

(c) Reckless Behavior: Corrective Action.

d. Managers should refer to Appendix "A" for appropriate actions in dealing with the employee/employees whether an actual safety event or the potential of a safety event.

5. RESPONSIBILITIES:

a. The AVAHS executive leadership team (Tetrad) is responsible to assure that all service chiefs, section chiefs and supervisors are aware of and follow this policy.

b. Service chiefs, section chiefs and supervisors are responsible for:

(1) Understanding and implementing this policy.

(2) Seeking guidance, when necessary, from the Tetrad sponsor for this policy.

(3) Facilitating a vigilant work team that is encouraged and expected to speak up when something is wrong.

c. All employees are responsible to speak out about reporting of adverse events, near misses, existence of hazardous conditions and related opportunities for improvement to leadership for the purposes of identifying opportunities for improvement and potential avoidance of future adverse events.

6. REFERENCE:

VISN 20 Executive Career Field (ECF) Plan 2014

VISN 20 Just Culture Tool Version 1.4 May 2015

7. RECISSION: None

**8. FOLLOW UP RESPONSIBILITY: Quality Management Service and Patient Safety
Manager.**



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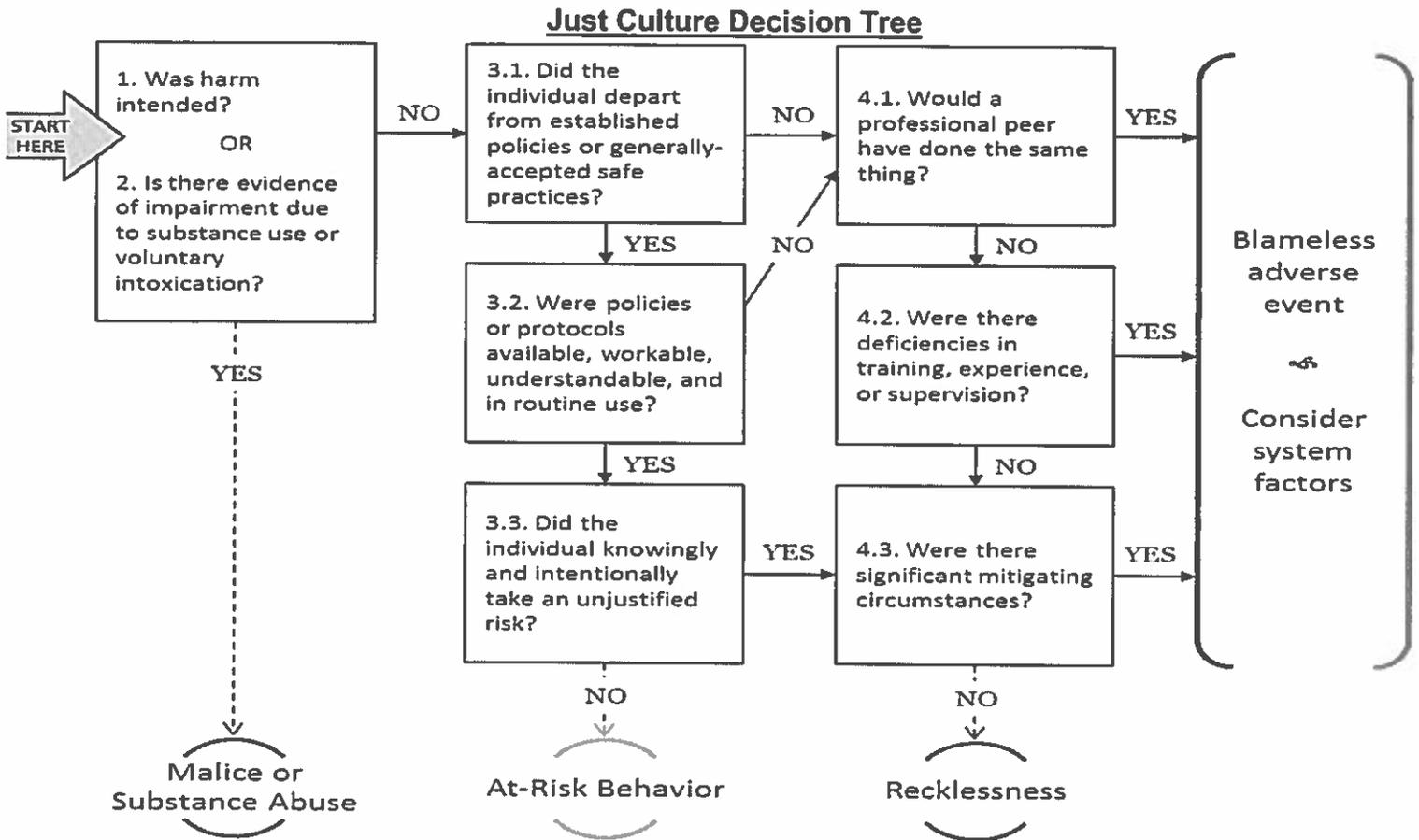
Attachments (2)

Distribution: All services

Guideline for Analyzing and Responding to a Patient Safety Event

Behavior/Actions	Human/System Error	At-Risk Behavior	Reckless Behavior
Definitions	Inadvertent action: Lapse, mistake	A choice: Risk not recognized or believed justified	Conscious disregard or unreasonable risk. Note: Repetitive at-risk behaviors may become reckless, however, the manager or chief must rule out the system's contribution to the repetitive behaviors.
Manage Through:	Changes in: <ul style="list-style-type: none"> ○ Processes ○ Procedures ○ Training ○ Design ○ Environment 	Remove incentives for at-risk behavior. Create incentives for healthy behaviors. Increase awareness of risks involved (situational awareness)	Consult with human resources to consider appropriate actions
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.	Consult with human resources to consider appropriate actions.

<p>Examples of Actions/ Behaviors</p>	<p>Physician orders 100 milligrams (mg) of drug instead of 10 mg.</p> <p>Registered Nurse (RN) is constantly interrupted during medication administration to attend to patient's 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 Operating Room (OR) instead of interventional Radiology.</p>	<p>RN labels blood specimen at nursing station rather than at bedside because he/she has never heard of or been involved in a mislabeling incident.</p> <p>Technician does not check two (2) patient identifiers and labels x-rays with wrong name.</p> <p>A housekeeper brings bleach from home and places it in his/her mop water in hopes of providing better cleaning and a fresher smell.</p> <p>He/she is assigned to clean up a spill of formaldehyde which has an adverse chemical reaction to the bleach in his/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>
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Adapted from Meadow, S., Baker, K. & Butler, J. (2005). The incident decision tree: Guidelines for action following patient safety incidents. In K. Henriksen, J. Battles, E. Marks, Eds., *Advances in patient safety: From research to implementation (volume 4)*. Retrieved from <http://www.ncbi.nlm.nih.gov/books/NBK20586/> and Reason, J. (1997). *Managing the risks of organizational accidents*. Burlington, VT: Ashgate.

