POLICY	Just Culture	DOMAIN
III-35		Governance and Ethics

SLT Sponsor: Chief Quality and Privacy Officer	**Date Approved:** April 11, 2023
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Policy Lead(s): Clinical Quality Consultant	**Date of Next Review:** April 2026

For further information please contact covenantpolicy@covenanthealth.ca

NOTE: The first appearance of terms in bold in the body of this document (except titles) are defined terms – please refer to the Definition section

Policy Statement:

Covenant Health is committed to the development and advancement of a workplace **just culture** grounded in safety, professional **accountability** and system improvement with provision of compassionate care and support of **patients, residents** and **health care providers.**

The principles of just culture and the focus on system design and response management are applicable throughout the organization and encompass a broad range of circumstances and service areas including clinical and non-clinical, where behavioural choices can result in an unexpected outcome.

Investigation and review of **clinical adverse events**, errors, **close calls** and **hazards** will occur within a compassionate, systematic process based on respect, trust, fairness, consistency and transparency with a focus on understanding system factors to improve safety.

A Just Culture does not equate to an accountability-free culture: healthcare providers will be held **accountable** for errors that warrant **disciplinary action** and may include behaviours such as:

- Deliberate and/or intentional acts to **harm** or deceive
- Evidence of criminal activity
- Knowing or reasonably understanding that harm would result based on action(s)
- Reckless behaviour
- Deviation from approved practices without rationale or justification
- Demonstrated lack of competency as per HR standards and requirements
- Unprofessional conduct as defined by the Health Professions Act (HPA)

This policy is in alignment with the Covenant Health Board of Directors Corporate Policy and Procedure 5.23 Just Culture.

Purpose Statement:

To outline Covenant Health's commitment to develop and promote a just culture within an organizational system of safety and accountability.

To establish open, straightforward dialogue between leadership, providers, administration and support services and create a workplace atmosphere of trust, equality, encouragement and commitment to safety, learning and continuous improvement.

To provide a just culture model of mutual accountability and shared responsibility between Covenant Health, employees, volunteers, contracted employees and physicians, that supports a consistent, fair, systematic and constructive approach to the response, decision-making and management of clinical adverse events (CAE), and also non-clinical errors, and the reporting of errors, close calls and hazards. To ensure the needs of patients, residents and families, Covenant Health staff and medical staff are managed and supported appropriately and effectively in the occurrence of a patient safety incident, across all disciplines and all departments

Applicability:

This policy and procedure applies to all Covenant Health facilities, staff, medical staff, volunteers, students and any other persons acting on behalf of Covenant Health.

Responsibility:

All Covenant Health facilities, staff, medical staff, students, volunteers and any other persons acting on behalf of Covenant Health.

Principles:

Guiding Principles: (adapted from Health Quality Council of Alberta (HQCA) Just Culture Principles)[1]

Just culture is a **learning culture** that is constantly improving and oriented toward patient and resident safety, as well as the psychological safety of staff. Capturing, tracking and learning from healthcare associated preventable harm is essential to the development of a just culture and ultimately, an organizational **safety culture**. The purpose of analysis in incidents of error, is for broad spectrum learning and system and process improvement.

Transparency:

Just Culture is a shared commitment to learning from error, clinical adverse events, close calls and hazards in an atmosphere of psychological safety; professional accountability is determined fairly and consistently and interests of both patients, residents and healthcare providers are protected.

Respect and Dignity:

Staff are encouraged and enabled to express concerns, report errors and safety issues with confidence and understanding that sharing and learning from events in a multidisciplinary and collaborative environment will help to prevent similar events in future.

Patients, residents, families or **alternate decision makers** (ADMs) are partners engaged in the process. Just Culture respects everyone who has questions or concerns about safety and/or risks. The Covenant Health Commitment to Ethical Integrity - Code of Conduct defining respectful behaviour will be upheld.

Support:

Healthcare providers, patients and residents will be treated with respect, dignity and compassion when a situation of harm or near harm occurs. This includes an absence of blame, naming or shaming of individuals involved in a situation of harm or near harm. Support may include services such as Critical Incident Stress Management (CISM), Employee and Family Assistance Program (EFAP), Peer Support, Spiritual Care, Human Resources, Quality and Patient Safety, and Patient Relations and Experience.

Respond Appropriately:

Event and/or error analysis supports and educates healthcare providers, patients and administrators, without punishment or blame for system-based errors or events beyond their control, or over which they have minimal influence. Actions are assessed fairly within the context of the system and what was occurring at the time of the event with minimal influence of bias in interpretation of facts.

Due care is required to minimize the effects of biases and heuristics (mental shortcuts) when reviewing behaviours after a clinical adverse event. These **biases can lead to mistaken conclusions and unfair or incomplete judgments about an individual's actions** in relation to an event. (**See definitions pg. 4**)

Some common biases are:

a) **hindsight bias**: knowing the end result, often based on information that may not be evident or readily available at the time of the event can lead to flawed conclusions that the outcome was more predictable and preventable than it actually was.

b) **outcome bias**: the severity of the outcome influences the assessment of the event without consideration of the circumstances or potential contributing factors.

c) f**undamental attribution**: may lead to attributing the event to something about the individual, rather than the circumstances or situation, including perceptions related to personality and/or character rather than facts.

Understanding and Accountability:

Healthcare is complex and most errors can be traced to breakdown or failure in systems and processes, and are rarely intentional acts.

A just, patient safety culture requires systematic assessment, considered in the context of the situation, and reviews all contributing factors including system error and human factors.

Psychological safety is an important component of just culture. It allows people to speak openly and ask for help or input. Teams with a high degree of psychological safety experience improved learning, better risk management, innovation, and a greater sense of job satisfaction and meaning.[3] Within a Just Culture, when harm occurs or an error is made, the actions of those involved are assessed fairly and, if applicable, independent of patient outcome.

System-based error includes more than technical and/or equipment failure. **Human factors**, part of the science of patient safety, takes into account the interaction between staff and all other elements

of the healthcare system, including interaction with the work environment, tasks, equipment, communication etc.

Individual accountability In rare circumstances, accountability can include individual **culpability** as determined through investigation and review of circumstances. (Refer to Appendix A, Just Culture Guide).

Disclosure:

Just Culture is supported through standardized and appropriate prompt, transparent **disclosure** about the events leading to a serious clinical adverse event, hazard or harm.

Definitions:

[2]**Accountable:** Expectation to provide an account, reason or explanation for one's own actions.

Accountability is the continuous process of monitoring one's professional conduct, requires independent thought, involves explaining and justifying actions based on sound professional knowledge and is transparent, logical and replicable decision-making, whereas responsibility traditionally means performing tasks in an accurate and timely way. (Savage and Moore 2004)

Alternate Decision-maker: A person who is authorized to make decisions with or on behalf of the patient; a minor's legal representative, a guardian, a 'nearest relative' in accordance with the Mental Health Act (Alberta), an agent in accordance with a Personal Directive, or a person designated accordance with the Human Tissue and Organ Donation Act (Alberta).

Close Call: An event that has potential for harm and is intercepted or corrected prior to reaching the patient/resident.

Clinical Adverse Event (CAE): Means an event that reasonably could or does result in an unintended injury or complications arising from health care management, with outcomes that may range from (but are not limited to) death or disability to dissatisfaction with health care management, or require a change in patient care.

Culpability: Responsibility for a fault or wrong; blame.

Disciplinary Action: Actions beyond remedial; up to and including punitive action or termination; the practice of using punishment to correct disobedience to rules or a code of behaviour.

Disclosure: The formal process involving an open discussion between a patient/resident and staff of Covenant Health about the events leading to a serious clinical adverse event, hazard or harm.

[2i]**Error (Human):** Is an unintended action which, by definition, is inevitable and unintentional;

- slip: failure in attention or perception;
- lapse: failure in memory
- mistake: failure in the mental processes involved in assessing available information making a plan, forming intention or judging the likely consequences of a planned action

Family(ies): One or more individuals identified by the patient as an important support, and who the patient wishes to be included in any encounters with the health care system, including, but not limited to, family members, legal guardians, friends and informal caregivers.

Fundamental attribution: the tendency to interpret the actions and behaviours of others based on their characteristics and personality.

Harm: An unexpected outcome for the patient/resident, resulting from the care and/or services provided, that negatively affects the patient's/resident's health and/or quality of life.

Hazard: A situation or circumstance that could escalate into an adverse event or close call (e.g. equipment malfunction).

Healthcare Provider: Those involved with the delivery of healthcare services to patients and residents on behalf of Covenant Health.

Healthcare Professional: An individual who is a member of a regulated health discipline, as defined by the Health Disciplines Act (Alberta) or the Health Professions Act (Alberta) and who practices within scope and role.

Hindsight bias: The tendency to process and analyze information in such a way that it supports pre-existing ideas and convictions; knowledge about the outcome of an event (hindsight) results in unrealistic expectations that those involved should have been able to anticipate what would happen and thus make different decisions.

[2] [ii]**Human Factors:** Knowledge about human abilities, human limitations, and other human characteristics. Human factors can be applied to designing safety systems and to understanding what influenced the choices individuals made when something went wrong.

[2iii]**Just Culture:** An atmosphere of trust in which people are encouraged to report adverse events, close calls and hazards. A just culture describes a work environment in which individuals believe they will receive fair and just treatment when involved in an adverse event. Expectations are also clear between acceptable and unacceptable behaviour.

Learning Culture: An organization with a commitment to continuous improvement; a willingness and ability to draw correct conclusions from a safety information system; preventable patient safety incidents are seen as opportunities for learning and changes are made as a result.

Outcome bias: An error made in evaluating the quality of a decision when the outcome of that decision is already known. The greater the severity of the outcome, the more critical the judgement is of the individuals and the decisions they made during the situation.

Patient or Resident: All persons who receive or have requested healthcare or services from Covenant Health and its **healthcare professionals** or individuals authorized to act on behalf of Covenant Health; also where applicable:

a) A co-decision-maker with the person; or

b) An alternate decision-maker on behalf of the person

Safety Culture: Cumulative effects of three elements of culture – reporting, just, and learning – characterize an organization with a safety culture.

Relevant Covenant Health Policy and Policy Support Documents:	
A.	**Policies:** III-45 Clinical Adverse Events, Close Calls and Hazards III-70 Disclosure of Wrongdoings and Protection of Persons who Disclose Wrongdoings
B.	**Procedures:** III-45.PROC.2 Disclosure of Harm III-45.PROC.3 Ongoing Management of Clinical Adverse Events, Close Calls and Hazards
C.	**Guidelines:** Our Commitment to Ethical Integrity, Covenant Health Code of Conduct, 2016
D.	**Job aids:** III-35.JOBAID.1 Just Culture Guide III-35.JOBAID.2 Patient Safety Incidents – Options for Evaluation and/or Response
E.	**Standards:**
Keywords:	

References:

Alberta Health Services Just Culture https://insite.albertahealthservices.ca/qhi/Page4742.aspx

[1]"A Just Culture Guide" | NHS Improvement. (2018). Retrieved from https://improvement.nhs.uk/resources/just-culture-guide/

Canadian Medical Protective Association (CMPA) Just Culture https://www.cmpa-acpm.ca/serve/docs/ela/goodpracticesguide/pages/patient_safety/just_culture/just_culture_safety-e.html

Creating a culture of accountability promotes safe medical care. (Canadian Medical Protective Association, 2018)

English Oxford Living Dictionaries. Definition: culpability [Internet]. 2018 [cited 2018 May 6] Retrieved from: https://en.oxforddictionaries.com/definition/culpability

Gino, Francesca; Moore, Don A.; Bazerman, Max H. (2009). "No Harm, No Foul: The Outcome Bias in Ethical Judgments" (PDF). SSRN 1099464. Harvard Business School Working Paper, No. 08-080

[2] Health Quality Council of Alberta (HQCA) Just Culture website Glossary: Terms to Avoid [Internet] 2018 [cited 2019 June 11] https://justculture.hqca.ca/glossary-terms-to-avoid/

Health Quality Council of Alberta (HQCA) Just Culture website Building trust for safer patient care 2019 Feb 5 https://justculture.hqca.ca/

[2i]Health Quality Council of Alberta (HQCA) Definition: human error [Internet]. 2018 [cited 2019 May 6] Retrieved from: https://justculture.hqca.ca/glossary-recommended-terms/

[2ii]Health Quality Council of Alberta (HQCA) Definition: human factors [Internet]. 2018 [cited 2019 May 6] Retrieved from: https://justculture.hqca.ca/references/#reference-14

[2iii]Health Quality Council of Alberta (HQCA) Definition: Just Culture [internet]. 2018 [cited 2019 May 6] https://justculture.hqca.ca/glossary-recommended-terms

Henriksen K, Kaplan H. Hindsight bias, outcome knowledge and adaptive learning. BMJ Qual Saf 2003;12 (Suppl 2).

Just Workplace Framework, Covenant Health, 2015 https://www.compassionnet.ca/AboutUs/2015_June5_About_MVV_JustWorkplaceFramework.pdf

Learning from adverse events: Fostering a just-culture of safety in Canadian hospitals and health care institutions. Ottawa, ON: Canadian Medical Protective Association 2009.

Marx D., Console, coach or punish: How reactions to behavioural choices influence culture. In: 2017 Michigan Health and Hospital Association Patient Safety and Quality Symposium; 8 March 2017; Dearborn

Meadows S, Baker K, Butler J. The Incident Decision Tree: Guidelines for Action Following Patient Safety Incidents In: Henriksen K, Battles JB, Marks ES, et al., editors. Advances in Patient Safety: From Research to Implementation (Volume 4: Programs, Tools, and Products). Rockville (MD): Agency for Healthcare Research and Quality (US); 2005 Feb. https://www.ncbi.nlm.nih.gov/books/NBK20586/

Reporting and responding to adverse events: A medical liability perspective. Ottawa, ON: Canadian Medical Protective Association; 2009.

[3]Why is Psychological safety so important in Healthcare? (Institute for Healthcare Improvement (IHI), 2017)

Past Revisions:

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