

HARRIS HEALTH SYSTEM

POLICY AND REGULATIONS MANUAL

Policy No: 3466
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Effective Date: 3/17
Board Motion No: N/A

Last Review Date: 07/30/2020
Due For Review: 07/30/2023

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 and to all working environments within Harris Health whether clinical, operational or administrative.

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 align 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, including system lapses.
- B. **BEHAVIORAL CHOICES:** Behavioral Choices are defined as the following:

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1. **HUMAN ERROR:** Inadvertently doing other than what should have been done: a slip, lapse, mistake, or inadvertent action.
 2. **AT-RISK BEHAVIOR:** Behavioral choice where risk is unintentional, not recognized or mistakenly believed to be justified.
 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 the following:
1. Competent professionals make mistakes and develop unhealthy norms;
 2. The ability to recognize errors may result from systemic factors;
 3. Individuals should not be treated punitively for system defects.
 4. An atmosphere where Workforce members can freely discuss Events without the fear of reprisal, through an objective assessment of events, which in turn promotes system modifications is necessary; and
 5. Reckless Behavior, gross misconduct, or willful violations will not be tolerated.
- D. **LEADERSHIP:** For the purposes of this policy, the term shall include Harris Health System's Board of Trustees, senior leaders (supervisor level and above), and leaders of the Harris Health Medical Staff.
- E. **EVENT:** Any variance not consistent with the desired, normal, or usual operations of the organization. Events can involve patients, Workforce members, visitors, or others. An injury does not have to occur. Events can include, but are not limited to, Adverse Events, Incidents, Near Misses and Sentinel Events as defined in Harris Health System Policy and Procedures 3.63 Incident Reporting and Response.
- F. **WORKFORCE:** Harris Health Board of Trustees, employees, medical staff, trainees, contractors, volunteers, and vendors. .

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II. GENERAL PROVISIONS:

- A. Just and Accountable Culture (JAC):
1. The overarching goal of 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 or other concerns without fear of retribution;
 - c. Harris Health System has become or is in the process of becoming a high reliability organization.
 - d. System process improvements that consist of using a standardized methodology (i.e., tools and processes) for assessing, reviewing, and managing errors are enculturated; and
 - e. Increased staff and peer Accountability exists.
- B. Harris Health acknowledges 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).
- C. All inquiries into reported Events, whether clinical, operational or administrative, must include analysis of the JAC algorithm in Appendix B of this policy to determine the appropriate course of action.

III. PRACTICE / PROCEDURE:

- A. Workforce Member Responsibilities:
1. Avoid causing unjustified risk or harm (e.g. physical, financial, reputation, privacy, emotional).
 2. Look for the risks and hazards around you and report these to your supervisor without delay;

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3. Report Events immediately. Adverse Events, Incidents, Near Misses and Sentinel Events should be reported as outlined in Harris Health System Policy 3.63 Incident Reporting and Response. Incidents. All other Events should be reported to your leadership, Human Resources or Corporate Compliance;
4. Help to design safe systems; and
5. Manage safe choices:
 - a. Follow procedures; and
 - b. Make choices aligned with organizational values.

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

B. Responsibilities of Leadership:

1. Assure the cultural environment is one which promotes reporting of Events and handling such events consistently and fairly.
2. As part of the normal investigative process for any reportable Event, 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 four (4) classifications of behaviors/actions:
 - a. System Lapse
 - b. Human Error;
 - c. At-Risk Behavior; and
 - d. Reckless Behavior.
4. Harris Health System's Board of Trustees has the ultimate responsibility for safety and quality at Harris Health System. Therefore, the Board of Trustees is responsible for openly supporting and encouraging compliance with this policy.

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Harris Health System Policy and Procedures 3.63 Incident Reporting and Response

Harris Health System Policy and Procedures 6.09 Introductory Period

Harris Health System Policy and Procedures 6.20 Corrective Action

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
	2.0	Approved 07/30/2020	Structure and Organizational Standards Committee

APPENDIX A PROCEDURES AND RESPONSIBILITIES OVERVIEW

I. ALL WORKFORCE MEMBERS RESPONSIBILITIES AND EXPECTATIONS:

Responsibilities:

A Workforce member who fails to report or attempts to cover up the occurrence of an 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 an Event or Human Error as soon as the event has been discovered after taking appropriate immediate action.
2. Formal 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. 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).

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II. LEADERSHIP RESPONSIBILITIES AND EXPECTATIONS:

A. Responsibilities:

1. Harris Health Leadership assures the cultural environment is one which promotes reporting of Events, Human Errors, and that such Events will be handled consistently.
2. As part of the normal investigative process for any reportable 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 four (4) classifications of behaviors/actions:
 - a. System lapse
 - b. Human Error;
 - c. At-Risk Behavior; and
 - d. 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:

Upon formal notification of an 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.

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APPENDIX B: PERFORMANCE MANAGEMENT ALGORITHM

To further assist in the appropriate evaluation of individual behaviors/actions, Human Resources and/or the Risk Management and Patient Safety Department are available to assist in using the following algorithms. They are tools 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.



PERFORMANCE MANAGEMENT ALGORITHM

Adapted from James Reason's Decision Tree for Determining the Culpability of Unsafe Acts and the Incident Decision Tree of the National Patient Safety Agency

