GUAM MEMORIAL HOSPITAL AUTHORITY
ADMINISTRATIVE MANUAL

APPROVED BY:	RESPONSIBILITY:	EFFECTIVE DATE:	POLICY NO.	PAGE
PeterJohn D. Camacho, MPH Hospital Administrator/CEO	Hospital-wide	May 28, 2018	A-PS820	1 of 10
TITLE: JUST CULTURE RESPONSE TO PATIENT SAFETY EVENTS				
LAST REVIEWED/REVISED: 10/2017				
ENDORSED: PSC 10/2017, NM 11/2017, MEC 01/2018, EMC 03/2018, Q&S 04/2018, BOT 04/2018				

PURPOSE:

This policy covers the key concepts of a *Just Culture* approach to investigating and following up on patient safety events, including the use of a Decision Tree to guide the investigator.

POLICY:

Guam Memorial Hospital Authority (GMHA) believes that a Just Culture is the cornerstone of a positive culture of patient safety. Attributes of a Just Culture include transparency, open and free communication around reporting of events, aligned objectives with the common goal of improving patient safety, appreciation of "Great Catches" and "No Harm Events" as opportunities and support for reporting any situation that threatens patient safety.

When patient safety events are investigated, including adverse events, no harm events and great catch events and it is determined that action(s) by a member of the GMHA care team contributed to the event, the assessment will include use of the Just Culture Decision Tree as a tool to assist in analysis and decision making. The Just Culture Decision Tree helps identify individual accountability and system failures. Responsibility for addressing system failures lies with the appropriate leadership representatives. While the Just Culture Decision Tree is a tool to guide the investigation process, it is used in conjunction with other evidence such as past performance of individuals involved in the event.

The Risk Management Program Officer and the Patient Safety Officer are available to assist investigators with use of the Just Culture Decision Tree, as appropriate.

DEFINITIONS:

Just Culture: The following describes a Just Culture:

- Establishes a learning environment rather than a blaming environment
- Establishes accountability in the context of the system in which the incident occurs
- Is *not* a non-punitive (blame free) environment
- Holds individuals accountable for their own performance *but not system flaws*
- Promotes a culture of reporting and learning from incidents
- Ensures open discussion of adverse events
- Commits to improving and implementing change based on patterns/trends
- Incident investigations are fair and free from bias over the outcome of the incident or from hindsight

Error: An act of commission (doing something wrong) or omission (failing to do the right thing) that leads to an undesirable outcome or significant potential for such an outcome.

Human Error: Inadvertent action; inadvertently doing other than what should have been done; slip, lapse, mistake.

At-Risk Behavior: Behavior that increases risk where risk is not recognized, or is mistakenly believed to be justified.

Reckless Behavior: Behavioral choice to consciously disregard a substantial and unjustifiable risk.

Adverse Event: An event [which may or may not have been preventable] that causes death or harm to a patient.

No Harm Event: An event or error that has the potential to cause death or harm to patients.

Great Catch Event: An event or error where harm to the patient was prevented because of discovery and action. Sometimes called a "near miss."

PROCEDURE:

A. The Just Culture Decision Tree (see Attachment A) is the tool used to identify acts deserving of personnel actions, such as coaching, counseling and discipline, and acts resulting from one or more system failures which demand systemic correction.

B. The Just Culture Decision Tree should be used when a member of the GMHA care team is involved in a patient safety event. If more than one member of the care team is involved, it is essential to work through the Decision Tree separately for each person. Note: throughout the remainder of this procedure, the member of the care team under review will be referred to as "the individual" and the person leading the investigation will be referred to as the "investigator."

C. Ideally, the Just Culture Decision Tree should be used as soon as possible after the patient safety event, while facts are still fresh.

D. The Just Culture Decision Tree guides the investigator through a series of structured questions about the individual's actions, motives and behavior at the time of the event. The questions move through three sequential tests. Attachments B, C and D include additional information to guide the investigator in the use of the specific sections of the Decision Tree:

   1. The Deliberate Harm Test (Attachment B) – In few, exceedingly rare, cases, the intent of the individual was to cause harm. The Deliberate Harm test asks questions to help identify or eliminate this possibility at the earliest possible stage.

   2. The Foresight Test (Attachment C) – The Foresight Test examines whether protocols and safe working practices existed and were adhered to.

   3. The Substitution Test (Attachment D) – The final Substitution Test helps to assess how a reasonable, prudent peer would have been likely to deal with the situation.

E. When navigating through the Just Culture Decision Tree, it's important to answer the yes/no" questions based on evidence, not assumptions. Never make assumptions about the incident, the individual or the protocols and safe procedures in place at the time.

Record answers to the "yes/no" questions along with the facts/reasons why that decision was made.

F. During the course of navigating through each "test" in the Just Culture Decision Tree, it is essential to also evaluate related or unrelated system failures that might have directly or indirectly contributed to the event. Just because personal accountability has been determined, it is equally important to assess system accountability in order to develop a fair and just action plan.

G. For individuals who believe that a Just Culture approach to a patient safety event was not followed:

1. Please refer to GMHA Grievance Procedure available from the Human Resources (HR) Office (non-contractual employees).

2. Employees falling under a collective bargaining agreement may refer to their union contract's grievance process.

3. At any phase in the Grievance Procedure, the employee, the manager/administrator, or HR representative may request a consultative review of the case by the Administrator of Quality, Patient Safety, and Regulatory Affairs. The focus of this review is to assess the use of the Just Culture Decision Tree during the patient safety event investigation and render an opinion about the conclusions. This review will be considered by the manager/administrator, along with other pertinent facts, in determining appropriateness of the action taken as part of the Grievance process.

REFERENCES:

Boysen, P. G. (2013). Just Culture: A Foundation for Balanced Accountability and Patient Safety. The Ochsner Journal, 13(3), 400-406. Retrieved from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3776518/

Joint Commission. (2017) Patient Safety Systems Chapter. Comprehensive Accreditation Manual for Hospitals: Chicago, IL.

Khantri, N., Brown, G.D., and Hicks, L.L. (2009). From a Blame Culture to a Just Culture in Health Care. Health Care Manage Review, 34(4). Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/19858916.

Tocco, S. and Blym, A. (2013). Just Culture Promotes a Partnership for Patient Safety. American Nurse Today, 8(5). Retrieved from https://www.americannurse today.com/just-culture-promotes-a-partnership-for-patient-safety/.

RELATED POLICIES:

A-PS800, Patient Safety Program, of the Administrative Manual.

RESCISSION:

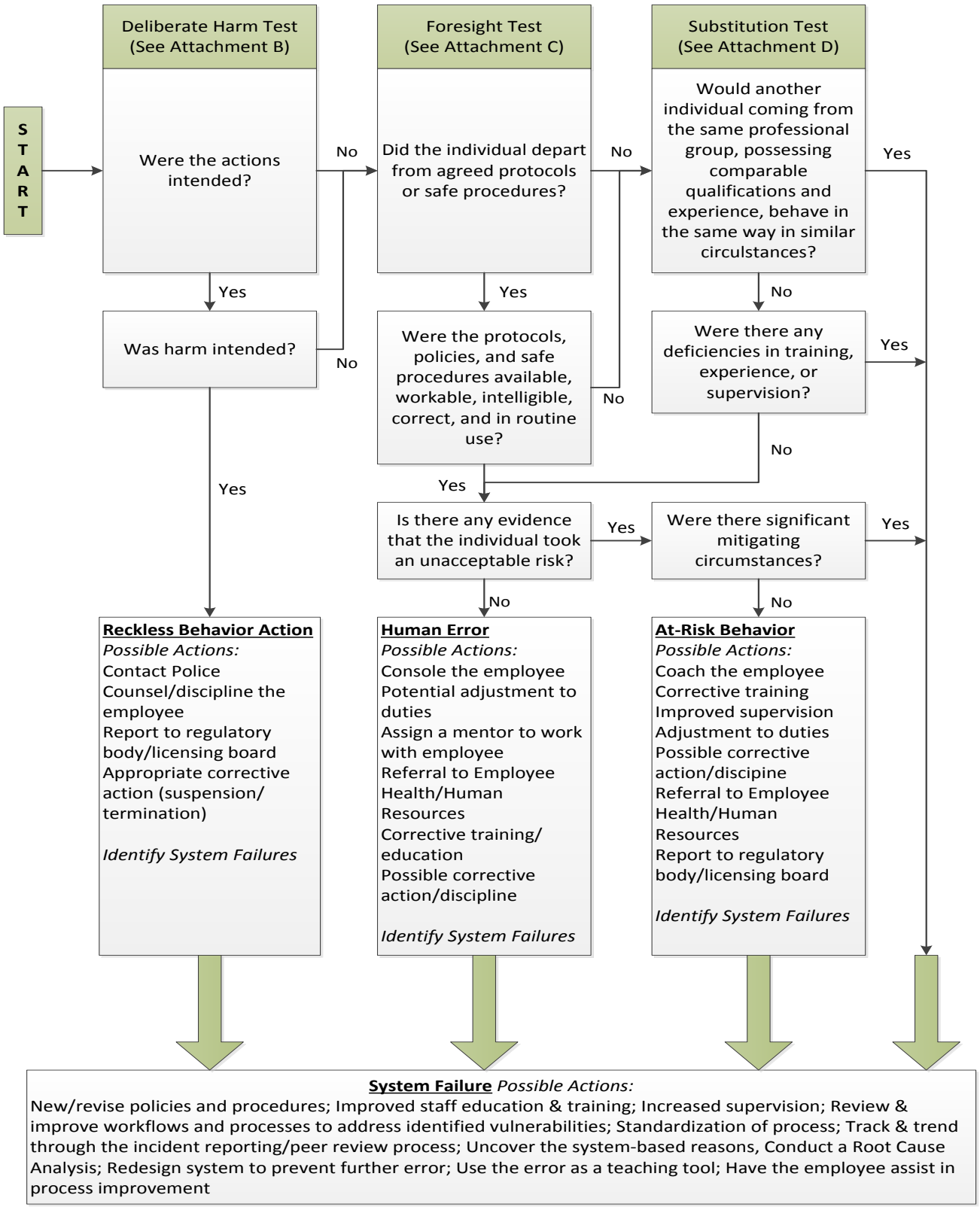
A-PS820, Just Culture Response to Patient Safety Events, of the Administrative Manual interim approved October 24, 2017.

ATTACHMENTS:

A. The Just Culture Decision Tree
B. Deliberate Harm Test
C. Foresight Test
D. Substitution Test

ATTACHMENT A:

The Just Culture Decision Tree



ATTACHMENT B:

Deliberate Harm Test
Supplemental Information/Guidelines

Overview: In the overwhelming majority of patient safety events, the individual had the patient's wellbeing at heart. However, in a few exceedingly rare cases, the intent was to cause harm. The Deliberate Harm Test asks questions to help identify or eliminate this possibility at the earliest possible stage.

Question #1: Were the actions intended?

This question asks whether the actions were as intended, not whether the outcome was as intended. This is an important distinction. Remember also that acts of omission are as important as acts of commission, so apply the question in the same way to cases that involve slips, lapses, general forgetfulness or a decision not to take action.

Scenarios	Guidelines for Assessment
A nurse injects a patient with drug X instead of drug Y.	The question is whether the nurse intended to administer drug X , not whether she intended the patient to die
A doctor carries out an operation on child A instead of child B, as a result of which child A is disfigured.	The question is whether the doctor intended to operate on child A, not whether he intended child A to be disfigured

Examples

- Failing to administer medication
- Failing to call the Code 72 Team
- Failing to write-up
- Deciding not to seek a second opinion in a difficult case
- Failing to check a patient's health record

Consider whether the individual:

- Forgot to take the action
- Was prevented from taking the action
- Decided not to take the action
- Refused to carry out an instruction

Question #2: Was harm intended?

This question tries to identify the individual's motives for taking the action they did. In most cases, where the actions were as intended, the individual did not mean the patient harm. Consider whether the individual actually meant the patient harm. The likelihood is that they did not. Examples of intended consequences:

• Deliberately giving a patient a wrong drug, with the aim of causing pain, disability or death
• Deliberately disconnecting an infusion pump
• Attacking a patient
• Deliberately withholding vital medications from a patient
• Deliberately failing to ventilate an elderly patient
• Using painkiller or mood-altering drugs prescribed for a patient on themselves or a third party
• Restraining a patient unnecessarily or for too long

ATTACHMENT C:

Foresight Test
Supplemental Information/Guidelines

Overview: The Foresight Test is used to determine whether policies & procedure and safe working practices existed and were properly adhered to. This test does not try to remove an individual's personal responsibility for their actions, but sets it in the context of potential problems with policies and procedures.

Question #1: Did the individual depart from agreed policies & procedures or safe working practices?

This question requires clarifying whether the action was governed by a policy/procedure (P/P). Do not:

- Assume a P/P exists—check for evidence
- Assume the individual received instruction on safe procedures during their professional training—check for evidence
  Answer "yes" to this question if it is confirmed that a P/P exists and the individual failed to follow it (for whatever reason).

Question #2: Were the policies, procedures and safe procedures available, workable, intelligible, correct and in routine use?

If a P/P exists, do not assume that it is workable and in routine use. Consider the following when answering this question:

- Was the P/P clear?
- Was the individual unwittingly applying an outdated P/P?
- Were conflicting P/P's in circulation?
- Was the P/P technically accurate but too laborious to apply routinely?
- Did the P/P promote correct and sensible action?
- Had the individual received information/training about the P/P?
- Did the individual decide not to apply the P/P? If so, you need to establish their reason:
  - If their action stemmed from difficulties in applying the P/P, you would answer "no"
  - If there was another reason, you would normally answer "yes"
- Did the individual cut corners because they knew the P/P so well?
  - Sometimes the individual was so familiar with the P/P they felt over-confident about cutting corners. Corner cutting usually causes problems where the case concerned turns out to be atypical.
  - It should be determined whether the individual is alone in cutting corners or whether the corner cutting is routine in the work environment.

Scenario	Guidelines for Assessment
Following a theft, a cardiac unit introduced a locked-drugs policy. However, night duty staff thought it unsafe to leave patients in outlying beds long enough to obtain adrenaline from the new drug cabinet. After raising the issue to no avail, nurses started to store adrenaline ampoules in the desk drawer to gain speedier access. Some	In this case, a procedure introduced for a sound reason proved unworkable, leading to a dangerous situation. The investigator answered "no" to this question.

ampoules fell onto the floor and a visiting child was found playing with them.	

Question #3: Is there evidence that the individual took an unacceptable risk?

This question asks you to consider whether the individual took a risk that would normally be considered unreasonable in the service concerned. It is probably the most difficult question to answer and careful judgment needs to be exercised. There are many reasons why an individual might violate a sound protocol. Sometimes the individual violates a protocol for no apparent or explicable reason. Generally, the more control the individual had over the situation, the more likely you are to decide they took an unacceptable risk.

The table below illustrates common reasons sound protocols are violated:

Habit	If the individual was working in an environment where cutting corners or ignoring protocols was endemic, it could be argued that they knew no different or that they should not be penalized for common practice
Someone else's benefit	Example: An ED physician gives priority to an adult friend with a minor cut over a child with a high fever.
Their own benefit	Examples: Cutting corners to leave work early; paying more attention to chatting with a colleague than to the task at hand.
Arrogance	Example: a midwife took it upon herself to deliver a baby via suction, despite the hospital's policy that this procedure be carried out by an obstetrician. Subsequently, the midwife explained that she knew she could perform this type of delivery as well as any doctor.
Failure to exercise self-discipline	Examples: physical or verbal retaliation; refusing to work collaboratively with a member of the health care team because of a personality conflict

Other factors to take into account when answering the questions include:

- Information available to the individual at the time
- Choices in front of them
- Speed with which they had to make a decision
- Degree of awareness they had of the risk being created

Scenario 1	Scenario 2
A staff nurse working on a busy unit was called to deal with a violent relative and forgot to give a diabetic patient their insulin. NO, this nurse did not take an unacceptable risk.	Another staff nurse forgot to give a patient their diabetic insulin because she popped into the day room to catch an episode of her favorite television show. YES, this nurse took an unacceptable risk.

ATTACHMENT D:

Substitution Test
Supplemental Information/Guidelines

Overview. The Substitution Test assesses how a peer would have been likely to deal with the situation. This test also highlights any deficiencies in training, experience and supervision that may have been involved in the patient safety event.

Question #1: Would another individual coming from the same professional group, possessing comparable qualifications and experience, behave in the same way in similar circumstances?

- When answering this question, consider what a "reasonable" peer acting sensibly, maturely and sensitively would have done.
- Example: A patient told a radiographer that she was feeling heat from the x-ray equipment. The radiographer dismissed the concerns and continued with the procedure, as the protocol advised switching off the machine only if the malfunction warning light appeared. It transpired that the warning system had failed and the patient suffered burns as a consequence.
- The investigator decided that a peer would have been likely to heed the patient's concerns and answered "no" to this question.

Question #2: Were there any deficiencies in training, experience or supervision?

This question considers whether the individual was properly equipped to deal with the situation. If not, a system failure is indicated. Factors to consider:

- Gaps or deficiencies in the individual's training
- Insufficient experience to handle the situation
- Inadequate supervision

Training	Look into any training the individual received and make sure it was comprehensive; well-designed; and effectively delivered.
Supervision	Check that supervision was both active and supportive. Do not make assumptions about the standards of training or supervision received. Sometimes, a lack of training or supervision can affect an individual's ability to apply common sense and "think on their feet." If this is the case, additional coaching or support may be necessary.

Example: A newly qualified nurse was asked by another nurse to "draw up a syringe of erythromycin" and give it to a sick child. The new recruit assumed this meant an IV syringe and duly injected the child with the drug. The child died as a consequence. The drug was in syrup form and the nurse meant for an oral medicine syringe to be used but the senior nurse did not confirm with the new nurse that she understood the instruction. This case involved both inadequate supervision and deficiencies in training. In this case, the investigator answered "yes" to this question and addressed system failures.

Question #3: Were there significant mitigating circumstances?

If you decide the individual took an unacceptable risk, you next need to consider any mitigating circumstances. Mitigating circumstances may or may not be significant enough to affect the action plan, but they must be set in the context of all the other factors involved in the case. Mitigating circumstances fall into four broad categories: Work pressures; external pressures; environmental factors; personal physical/mental health factors

The table below illustrates common mitigating circumstances:

Work pressures	Tiredness; short-staffing; bullying; anxiety about job security; lack of management support Example: A clinical lab technologist failed to notice a critical lab results which should have been called immediately to a practitioner. As a result, the patient's condition deteriorated and resulted in the need for resuscitation. The individual maintained that tiredness had impaired her judgment and observation. She had been on duty for 15 hours without a break and had worked a total of 65 hours over the previous five days to cover colleagues' absences. The investigator decided that the individual took an unacceptable risk, but that mitigating circumstances pointed to a system failure.
External pressures	Anxiety or preoccupation about events or problems outside of work. They might involve needing to leave work promptly or early to care for dependents or to deal with a personal issue. Example: A nurse connected the wrong IV drip just after receiving news that her son had been involved in a serious traffic accident.
Environmental factors	Distraction; difficult working conditions; shortage of supplies Example: A Code 72 team had difficulties defibrillating a patient because the patient's bed was jammed against the wall and they could not reach her easily.
Personal Physical/Mental Health Factors	Consider any known facts or observations about the individual's physical or mental health that might be pertinent to the investigation. Always confer with HR if there is any possibility that this may be a factor.