Name of Policy: Just Culture **Policy Number**: 3364-100-50-48 **Approving Officer**: Chief Medical Officer, Chief Executive Officer, Chief of Staff **Responsible Agent**: Chief Medical Officer **Scope**: University of Toledo Medical Center	UTOLEDO HEALTH **Effective date:** 5/2025 **Original effective date**: 3/1/2022
Key words: Just Culture, Adverse Events, Outcomes, Human Error, System Level Evaluation	

☐	New policy proposal	☒	Minor/technical revision of existing policy
☐	Major revision of existing policy	☐	Reaffirmation of existing policy

(A) Policy statement

Just Culture recognizes that adverse events and unanticipated outcomes are often the result of human error, or system failures, rather than the result of reckless or intentionally malicious behavior, and that individuals are accountable for their individual actions, but generally not errors or problems in system design. To foster this, UTMC will utilize a fair and systematic approach that balances a nonpunitive learning environment with the equally important need of accountability. This shall include evaluation for system level issues that allow unwanted human error or behavioral choices and identification of process improvement opportunities that will prevent or minimize potential harm.

(B) Purpose of policy

Our goal at UTMC is to improve health in the communities and region we serve. Every effort that falls short of the intended result provides a learning opportunity and an improvement opportunity. System design, system effectiveness, and individual performance all contribute to outcomes, therefore analysis of adverse or unintended results must fairly assess all aspects of the events. The purpose of this policy is to establish a framework for and commitment to Just Culture at UTMC as part of the journey of a High Reliability Organization.

(C) Scope

Applies to all staff, including physicians, employed by, or providing services at UTMC (all locations and departments).

(D) Procedure

The interpretation, administration, and monitoring for compliance of a Just Culture will be the responsibility of operational leadership in collaboration with Human Resources, Risk Management, Quality Management, and other departments, as necessary.

1. Leaders will promote a learning environment and educate all team members on the concept of Just Culture
2. Leaders will educate all staff members and ensure the use of the Just Culture Decision-Tree (see addendum): a tool to help determine the type of behavior displayed and the correct course of action when an individual has made an error, drifted into at-risk behavior or otherwise not met the expectations of the organization.
3. Leaders will foster an environment that promotes full disclosure of events
4. Leaders will lead or participate in cause analysis activities (Root cause or Apparent cause) and help lead a response focused on process and prevention
5. Leaders will actively seek and report areas of concern and potential harm and opportunities for improvement
6. Leaders may notify and include other directors, managers, senior leaders, and other healthcare team members depending on the severity of the concern or event

(E) Guiding principles

It is the expectation that all staff and physicians at UTMC will:
1. Actively seek to avoid causing a risk or harm to patients, visitors, or colleagues
2. Work diligently to achieve the goals and intended outcomes of the organization
3. Follow the policies, rules, and regulations of the organization
4. Report safety events, near misses, and other events through the occurrence reporting system
5. Be held accountable for their individual actions based on the quality of decision-making rather than the outcomes of decisions
6. Participate in cause analysis reviews as necessary

(F) References

Health Research & Education Trust. Culture of Safety change package, 2018
Joint Commission Comprehensive Accreditation Manual for Hospitals: Patient Safety systems, 2021
Marx, D., Just Culture Algorithm v3.2, 2012
Reason, J., Decision Tree for Determining Culpability of Unsafe Acts,1997

Approved by:

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Review/Revision Completed by: Chief Nursing Officer, Director, Quality Management, Chief Medical Officer

Policies Superseded by This Policy:

- *None*

Policies Linked to this policy:

- *3364-100-50-38 Patient Safety Event including Sentinel Events Policy*
- *3364-87-16 Impaired Licensed Independent Practitioners*
- *3364-87-90 Medical Staff Bylaws*
- *3364-87-38 Focused Professional Practice Evaluation Policy*
- *3364-25-111 Corrective action (Non-Collective Bargaining Unit Employees)*

Initial effective date: 3/1/2022

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3/1/22
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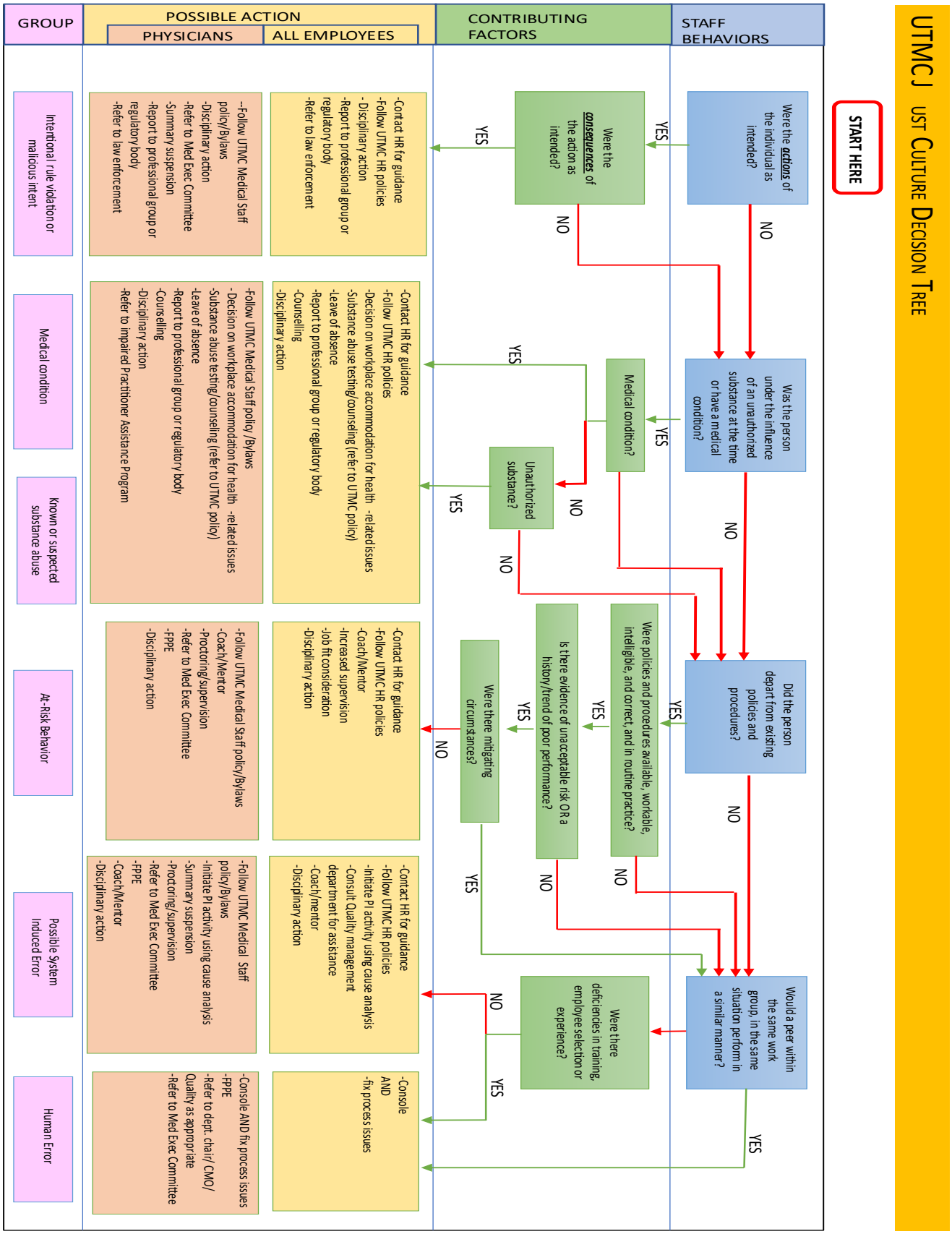
Addendum

Just Culture Decision-Tree

A Performance Management Tool for Adverse Events and Unsafe Conditions

What is Just Culture Decision-Tree	**A tool intended to assist in determining the type of behavior displayed and the correct course of action when an individual has made an error, drifted into at-risk behavior, or otherwise not met the expectations of the organization.**
When to Use This Decision Tree	Prior to issuing corrective action following an adverse event or near miss. In addition to and not in place of the Patient Safety Net reporting system.
Purpose	Encourages leaders to decrease the focus on individual blame and instead view an adverse event or near misses as an opportunity to console and re-educate staff, improve systems, and reduce risk.
How to Use This Decision Tree	First, thoroughly investigate the adverse event or near miss. Ensure that a Patient Safety Net report has been filed. Second: start at the top left of the tool, answer each question ‘yes’ or ‘no,’ and follow the arrows through the Decision Tree. Third: ensure any corrective action is based upon the employee’s behavior, not the outcome of the behavior (e.g., harm to a patient). Fourth: Enter corrective action plan into Patient Safety Net manager review if needed.
Tips for Leaders	1.Expect the vast majority of cases to result in an outcome requiring consoling the employee and look for system improvements or re-education opportunities and will not result in employee corrective action. 2. Encourage transparency. Share the steps of analysis and determine the action with the employee, when possible. 3. Always contact HR when you are unsure of appropriate corrective action or are considering suspension, decision making leave, or termination. When necessary, seek a second opinion from a fellow leader and HR.



This document serves as a guide, and is not a substitute for independent medical decision -making.

Definitions

High Reliability Organization	An organization that focuses on improving reliability through better process design, building a culture of reliability, and optimizing human factors by creating designs and processes that help people do the right thing.
Just Culture	A learning culture that is focused on balancing accountability with fairness.
Staff	All personnel working at all levels in UTMC or one of its departments example employees, locum tenens, contractors, volunteers, trainees, and other persons, clinical and non-clinical.
Near Miss	An event that could have caused harm but was averted.
Human Error	An event leading to an action not happening as it was intended, commonly described as a “slip,” “lapse,” or “mistake.”
Safety	Freedom from unjustified risk and preventable injury
Consoling	Expressing empathy and providing emotional support to someone in a time of grief or disappointment.
Coaching	The process of providing constructive feedback about engaging in safer behavioral choices. Ongoing feedback and coaching are used to communicate about, and reinforce appropriate behavior, teach new skills, motivate high performance, and mentor workforce members so they understand their role in the organization.
Counseling	Communication with an individual wherein a performance deficiency is identified and expectations for future performance are delineated. Counseling should be memorialized in writing by informal memo or confirmation email, and placed in the departmental personnel file, with a copy provided to the staff member involved. The staff member does not have to sign the document.
Disciplinary action	Action taken to ensure adherence to acceptable and reasonable standards of performance and conduct may include written warning, written reprimand, suspension, reduction/demotion, and discharge, applied in a progressive or non-progressive manner. Workforce members may ask for a union representative or witness (as applicable) if he or she feels a meeting may lead to discipline.
Reckless Behavior	A behavioral choice to consciously disregard a substantial and unjustifiable risk or failure to follow clear and known procedures.
Negligent Behavior	Failure to behave in the manner expected from someone who has the same knowledge and skills under the same circumstances.
Intentional Rule Violation or Malicious Intent	The intentional rule violation occurs when an individual chooses to knowingly violate a rule while he is performing a task. This concept is not necessarily related to risk taking but merely shows that an individual knew of or intended to violate a rule, procedure, or duty in the course of performing a task.
Root Cause Analysis	A root cause analysis is one type of comprehensive systematic analysis, which is a process for identifying basic or causal factors underlying variation in performance, including the occurrence or possible occurrence of a sentinel event.
Apparent Cause Analysis	A limited investigation, requiring fewer investigative resources, of a safety event resulting in limited or no harm with a focus on addressing immediate concerns and developing local preventative strategies.