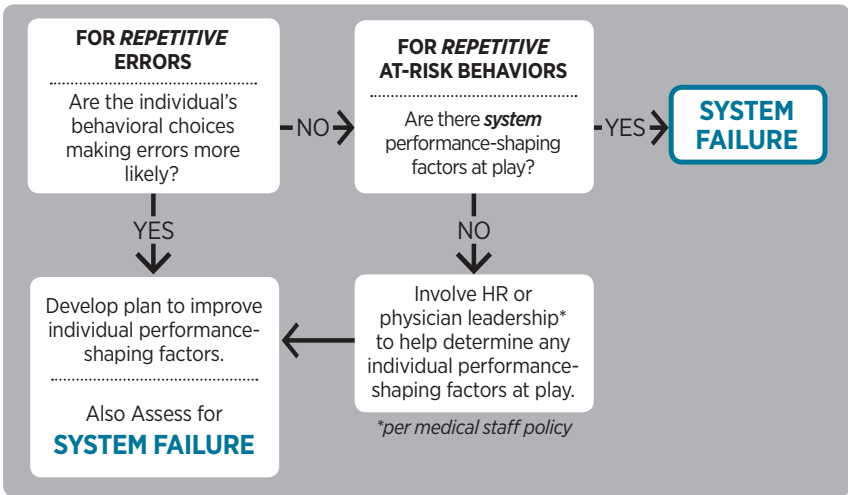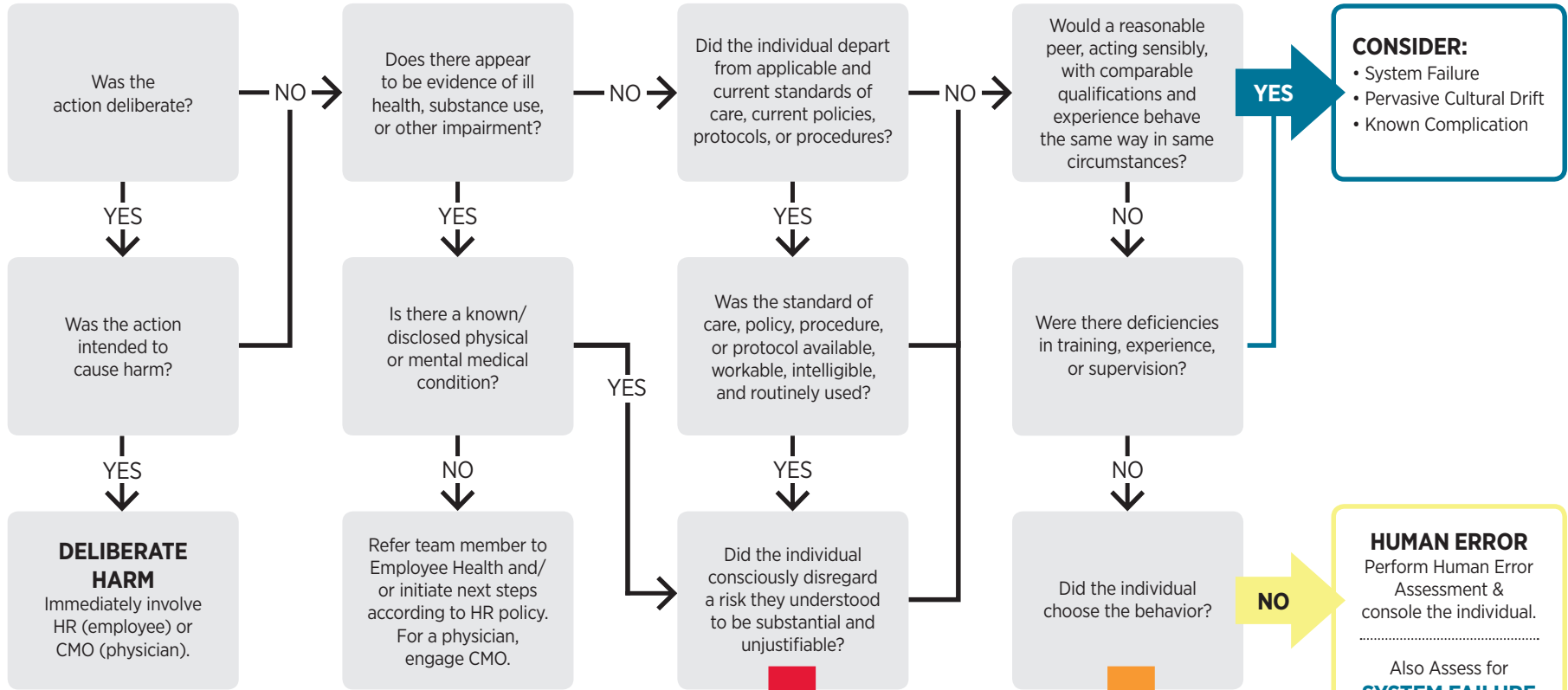# Just Culture ALGORITHM

This algorithm is a guide and should be used after performing an objective assessment of the situation. It helps to differentiate between individual and organizational accountability. The first step is to identify the specific action being evaluated. If you cannot answer a question, it is recommended to pause and try to establish facts through the individual(s) involved or present for the event. When you end at a colored box, flip to the Toolkit on the reverse side for guidance on next steps. Offer support to team member(s) involved; encourage them to use resources such as EAP or a peer support program (where available).

START HERE

Was the action deliberate? — NO →

Does there appear to be evidence of ill health, substance use, or other impairment? — NO →

Did the individual depart from applicable and current standards of care, current policies, protocols, or procedures? — NO →

Would a reasonable peer, acting sensibly, with comparable qualifications and experience behave the same way in same circumstances? — **YES** →

CONSIDER:
- System Failure
- Pervasive Cultural Drift
- Known Complication

YES ↓

Was the action intended to cause harm?

YES ↓

Is there a known/ disclosed physical or mental medical condition? — YES →

Was the standard of care, policy, procedure, or protocol available, workable, intelligible, and routinely used?

NO ↓

Were there deficiencies in training, experience, or supervision?

NO ↓

YES ↓

DELIBERATE HARM
Immediately involve HR (employee) or CMO (physician).

NO ↓

Refer team member to Employee Health and/ or initiate next steps according to HR policy. For a physician, engage CMO.

YES ↓

Did the individual consciously disregard a risk they understood to be substantial and unjustifiable?

YES ↓

Did the individual choose the behavior? — **NO** →

HUMAN ERROR
Perform Human Error Assessment & console the individual.
....
Also Assess for
SYSTEM FAILURE

YES ↓

RECKLESS BEHAVIOR
Consider remedial or corrective action.
....
Also Assess for
SYSTEM FAILURE

AT-RISK BEHAVIOR
Perform At-Risk Behavior Assessment & coach the individual.
....
Also Assess for
SYSTEM FAILURE

FOR *REPETITIVE* ERRORS
Are the individual's behavioral choices making errors more likely? — NO →

FOR *REPETITIVE* AT-RISK BEHAVIORS
Are there *system* performance-shaping factors at play? — YES → **SYSTEM FAILURE**

YES ↓

NO ↓

Develop plan to improve individual performance-shaping factors.
....
Also Assess for
SYSTEM FAILURE

Involve HR or physician leadership* to help determine any individual performance-shaping factors at play.

*per medical staff policy

Adapted from: National Patient Safety Agency's Incident Decision Tree (2003) & James Reason's Culpability Model (1997)

UNIVERSITY of MARYLAND MEDICAL SYSTEM

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Just Culture ⚖ TOOLKIT

SYSTEM FAILURE

The majority of staff try to provide a safe environment and prevent things from going wrong. Staff should not be held responsible for failures in the system.

System Failure Assessment:
How were risks being managed ahead of the event?

- Work pressures
- External pressures
- Environmental factors
- Training/Competency
- Technology
- Policies
- Communication
- Teamwork
- Staffing
- Barriers put in place to prevent error

Address by Changing:
Aspects of the system that allowed this event to occur.

DEVELOPING STRONGER SYSTEMS

Stronger Solutions

Architectural/physical plant changes

New devices with usability testing

Engineering Control (Forcing Function)

Simplify Process

Standardize equipment or process

Tangible involvement by leadership

Intermediate Solutions

Redundancy

Increasing staffing/decreasing workload

Software enhancements, modifications

Eliminate/reduce distractions

Education using simulation-based training, with periodic refresher sessions and observations

Checklist/cognitive aids

Eliminate look- and sound-alikes

Standardize communication tools

Enhanced documentation, communication

Weaker Solutions

Double-checks

Alerts/Warnings

New Procedure/Memorandum/Policy

Training

HUMAN ERROR

Not a conscious decision

Product of:

Current System Design **+** Human Tendencies

Human Error Assessment
Identify performance-shaping factors:

- Information
- Equipment/tools
- Job/task
- Qualification/skills
- Individual factors
- Environment/facilities
- Organizational culture
- Supervision
- Communication

Manage by Changing:
- Choices
- Processes
- Procedures
- Training
- Design
- Environment

CONSOLE

AT-RISK BEHAVIOR

Conscious choice where the individual either:

- Mistakenly believed the risk to be low
  or
- Mistakenly believed the risk to be justified

At-Risk Behavior Assessment
Type of at-risk behavior:
- Error in risk v. benefit decision
- Failure to make risk v. benefit decision

Why was the decision made?
- Incentives to cut corners?
- Perceptions of risk?

How prevalent is the behavior?
- Individual or group?
- How often?

Manage Through:
- Removing incentives for at-risk behaviors
- Creating incentives for appropriate behaviors
- Increasing situational awareness

COACH

RECKLESS BEHAVIOR

Conscious disregard of known substantial and unjustifiable risk.

Extremely rare among health care workers.

Manage Through:
- Remedial action
- Corrective action

DISCIPLINE