How Should Policy Reflect a Culture of Safety?
# Table of Contents

- How Should Policy Reflect a Culture of Safety? .......................................................... 1  
- Next Steps .................................................................................................................. 3  
- Section Library .......................................................................................................... 4  
- Section Resources ...................................................................................................... 5
How Should Policy Reflect a Culture of Safety?

Policies & Procedures

Policies are clear, simple statements of how your organization intends to conduct its services, actions or business. They provide a set of guiding principles to help with decision making. Policies don't need to be long or complicated. As a matter of fact, best practice statements suggest one page or less.

Procedures describe how each policy will be put into action. Each procedure should outline: who will do what, what steps they need to take and which forms or documents need to be completed. Procedures might just be a few bullet points or instructions attached to a policy. They usually work well as forms, checklists, instructions or flowcharts.

Policies and their accompanying procedures vary greatly among healthcare organizations, as they mirror the values, approaches and commitments of those who authored them. Additionally, Joint Commission surveyors have reported that a review of a facility’s policies gives them insight into their culture of safety.

Reflecting Culture of Safety Tenets through Policy

This might better be termed, eliminating the policies that don’t reflect Culture of Safety tenets. For example, any policy that does not encourage staff to speak-up about reporting of adverse events, near misses, and hazardous conditions or requires punishment for human error should be restructured. That said, oftentimes, a complete revamping of all policy wording is needed. However, this will take time, so start by removing the policies that are notable barriers and work incrementally to build the philosophy in as you go. Generally, policies that may need to be revised include your incident reporting policy, sentinel event policy, disclosure policy, patient complaint/grievance process, job description, codes of conduct, medical staff bylaws, rules and regulations, and the like.
For your HEART journey, starting with the organizational policies related to employee behavior expectations, consequences for behavior and event investigation would be most advantageous. As this chapter focuses on event investigation, we will further discuss Culture of Safety tenets associated with this type of policy.

Sentinel event investigation policies that say, "We will only look at systems and not human behavior" won't work. Likewise, a policy that only looks at behavioral response and negates a system review is equally insufficient. Cultures of Safety tenets include Just Culture principles (behavioral response) as well as organizational learning through systems review.

Any document that addresses the consequences for behavior and the management of adverse events will need to be revised to reconcile professional accountability and the need to create a safe environment to report medical errors. In other words, the staff needs to know that if an event occurred because of a system failure or flaw, then the organization accepts responsibility and accountability, and the individual will not be punished for something that was out of his or her control.

Leadership will need to understand that the reasons for clinical outcomes and events should not be the focus, nor should those involved be prejudged. Any rush to blame individuals is to be avoided. Rather, there should be an attempt to understand, at the time the event, the circumstances and context for the actions and decision-making. The main focus of this event analysis is on system failures, with any and all subsequent analyses and proceedings conducted with fairness and in accordance with established hospital policy and/or bylaws. The rights of all individuals are protected, for both employees and patients, and policies and procedures should reflect language that addresses:

- Leadership’s commitment to and support of trust, transparency, fairness, patient safety and organizational learning as central themes of event investigation
- The organization’s support of staff who report adverse events, near misses and hazardous conditions and intolerance of retaliation for said reporting
- The organization’s intolerance of intentionally unsafe actions, reckless actions, disregard for the welfare of patients or staff, or other willful misconduct and/or misbehavior
- Leadership appropriately protecting any applicable information from legal, regulatory, or other proceedings
An example of an event reporting policy that speaks to Culture of Safety principles is provided in “Section Resources.”

Next Steps

Not that we have taken on policy change, we will now discuss how event investigations should be carried out in a Culture of Safety.
Section Library


- BC Patient Safety & Quality Council: Culture Change Toolbox


- Institute for Healthcare Improvement: Culture of Safety Brochure


- Patient Safety Primer: High Reliability

- Psychological safety and error reporting within Veterans Health Administration hospitals. J Patient Saf. 2015 Mar;11(1)

Section Resources

Example Event Reporting Policy

Policy No: 5.24

**Subject:** Response to Safety Events – Just Culture

**Supersedes:** All existing corporate and business unit policies on this subject

**Effective:** October 8, 2008

**Revised:** July 1, 2002, December 1, 2012

**Reviewed:** December 1, 2012

**Pages:** 10

**Approved by:** Human Resources Executive Team (HRET) & Operational Leadership

1.0 PHILOSOPHY/PURPOSE

Henry Ford Health System believes in a “Just Culture” that encourages employee self-disclosure and continual delivery of high quality services for patients, employees, and the community it serves. HFHS wants employees to feel safe to speak-up and speak-out about reporting of adverse events, near misses, existence of hazardous conditions, and related opportunities for improvement as a means to identify systems changes and behavior changes which have the potential to avoid future adverse events.

We also recognize that employees must balance personal and organizational values with:

- The duty to avoid causing unjustified risk or harm
- The duty to produce an outcome
- The duty to follow a procedural rule

To this end, HFHS believes in a consistent, fair, systematic approach to managing behaviors that facilitate a culture that balances a non-punitive learning environment with the equally important need to hold persons accountable for their actions.
2.0 SCOPE/ELIGIBILITY

This policy applies to anyone working at any HFHS business unit or facility including, but not limited to: regular & contingent employees, physicians, agency staff, volunteers and contract workers.

3.0 RESPONSIBILITY

The interpretation, administration and monitoring for compliance of this policy shall be the responsibility of operational leadership in conjunction with Human Resources, Quality/Risk staff and other departments where necessary.

4.0 POLICY

HFHS takes the position that safety events are not commonly the result of individual misconduct (reckless behavior), but rather system or process failures (human error/at-risk behavior influenced by the system as designed).

All managers and leadership will proactively assure employees that the System’s culture promotes reporting of safety events and that such events will be handled consistently and fairly.

As part of the normal investigative process for any safety event, the manager will conduct an investigation to determine the type of behavior that led to the safety event and to distinguish between blameworthy and blameless actions. The safety event will be assessed objectively and analyzed using a systematic approach based on three classifications of behaviors/actions:

1. Human Error
2. At-Risk
3. Reckless
   (See Appendix A, Guidelines for Analyzing and Responding to a Safety Event).

Exceptions to this approach will occur if an individual knowingly or willingly conceals a safety event or hinders a safety investigation, or causes a safety event or commits an unsafe act that results from:

1. An illegal act
2. A breach of confidentiality
3. A purposeful or reckless unsafe act
4. An act committed under the influence of alcohol, other substances or involves drug diversion
5. A persistent issue not resolved through performance improvement. (See Corrective Action Program HR Policy No: 5.17)
5.1 Safety Event – A safety event is any variance not consistent with the desired, normal, or usual operations of the organization. Safety events can involve patients, employees, visitors or others. An injury does not have to occur.

5.2 Practice for all employees includes:

- Report a safety even as soon as the event has been discovered after taking appropriate immediate action.
- Formal reporting will be done using Online Redform Risk Reporting (create link).
- Safety event 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.
- 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.

5.2 Expectation of staff:

- Avoid causing unjustified risk or harm. (e.g. physical, financial, reputation, privacy, emotional) Look for the risks and hazards around you.
- Report errors and hazards (speak up)
- Help to design safe systems
- Manage safe choices:
  - Follow procedures
  - Make choices aligned with organizational values

5.3 Practice for managers:

All leadership shall take proactive measures to assure their employees that the System’s culture promotes full disclosure of safety events. Such events will be handled consistently with the System’s philosophy of responding with a focus on process, prevention and process improvement measures (versus punitive actions).

Upon formal notification of a safety event, operational leadership associated with the event will begin an investigation process to identify the type of behavior that led to the safety event. These three behaviors/actions are:

1. Human Error- slip lapse or mistake; unintended error and a product of a current system design that often fails to consider the impact of the human factor.
2. At-Risk- A choice: risk not recognized, risk of deviation deemed minimal or believed justified.
3. Reckless- Intentional risk taking; knows risk associated with action but consciously disregards risk.

(See Appendix A, Guidelines for Analyzing and Responding to a Safety Event).
5.4 Expectations for managers:

- Knowing the risk
  - Investigating the source of errors and at-risk behaviors
  - Turning events into an understanding of risk
- Designing safe systems
- Facilitating safe choices focused on managing behaviors:
  - Human Error – Consoling (e.g. providing emotional support, EAP and/or crisis management team appropriate to the situation)
  - At-Risk – Coaching (e.g. education, review of applicable standards, manage incentives)
  - Reckless – Corrective Action

Managers will follow Corrective Action policy for Reckless Behaviors including:

- Reckless disregard of the procedural risks associated with noncompliance.
- Reckless disregard toward harm to self or others OR
- When remedial action (e.g. education, coaching) is not effective in changing behavior

Assistance

To further assist in the appropriate evaluation of these individual behaviors/actions, Human Resources and clinical quality and safety leaders are available to coach managers using the Just Culture Algorithm. The Just Culture 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 obligations to the organization. Use of the algorithm is optional and intended for use by those who have had additional training in the tool. (See Appendix B, HFHS Just Culture Algorithm)

In accordance with applicable significant event or risk management guidelines, managers, senior leaders and other healthcare team members may be notified depending on the severity of the concern or event.

Attachments to Patient Safety HR Policy 5.24:

- Appendix A: Guideline for Analyzing and Responding to a Safety Event
- Appendix B: HFHS Just Culture Algorithm

See also HFHS related policies or links:

- Compliance Reporting, Investigation and Remediation Process C-005 Confidentiality and Information Security Policy 5.18
- Corrective Action Program Policy 5.17
Response to Safety Events – Just Culture Policy 5.24

Drug-Free Workplace Policy 5.11
Electronic Business Communications Policy 5.21
Health Professional Licensing and Disciplinary Reform Act 4.08 Performance Improvement Program Policy 5.10
RadicaLogic Online Redform: Risk – Reporting of Safety Events I.E.6 Sentinel Events and Critical Incidents 600.00
Whistleblower’s Protection Act Policy 4.12
REFERENCES:


**Appendix A: Guideline for Analyzing and Responding to a Safety Event**

<table>
<thead>
<tr>
<th>Behavior / Actions Classification</th>
<th>Human Error</th>
<th>At-Risk Behavior</th>
<th>Reckless Behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition</td>
<td>Inadvertent action: lapse, mistake</td>
<td>A choice: risk not recognized or believed justified</td>
<td>Conscious disregard of unreasonable risk (Note: Repetitive at-risk behaviors may become reckless but manager must rule out system’s contribution to the repetitive behaviors)</td>
</tr>
</tbody>
</table>

**Manage through:**

<table>
<thead>
<tr>
<th>Classification</th>
<th>Changes in:</th>
<th>Manage through:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Processes</td>
<td>• Remove incentives for at-risk behavior</td>
<td>Follow Corrective Action Program Policy: HR Policy 5.17</td>
</tr>
<tr>
<td>Procedures</td>
<td>• Create incentives for healthy behaviors</td>
<td></td>
</tr>
<tr>
<td>Training</td>
<td>• Increase awareness of risks involved (situational awareness)</td>
<td></td>
</tr>
<tr>
<td>Design</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Environment</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Response**

<table>
<thead>
<tr>
<th>Response</th>
<th>Console</th>
<th>Coach</th>
<th>Corrective Action</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>the person who committed human error. These errors should be seen as a product of the system in which the employee works. The systems are what have to be corrected. Managers, supported by leadership should identify and change error-prone processes, procedures and environments (since managers are responsible for the environment in which employees work.)</td>
<td>non-punitively. Identify, manage and coach at-risk behaviors proactively.</td>
<td>Follow Corrective Action Program Policy (HR Policy 5.17)</td>
</tr>
</tbody>
</table>

**Examples of Actions/Behaviors**

<table>
<thead>
<tr>
<th>Examples of Actions/Behaviors</th>
<th>Action</th>
<th>Action</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician orders 100 mg of drug instead of 10 mg.</td>
<td>RN labels blood specimen at nursing station rather than at bedside because she has never heard of or been involved in a mislabeling incident.</td>
<td>Professional provides patient care while intoxicated.</td>
<td></td>
</tr>
<tr>
<td>RN is constantly interrupted during medication administration to attend to patient’s needs.</td>
<td>Technician does not check 2 patient identifiers and labels x-rays with wrong name.</td>
<td>Prior to administering blood, RN falsifies a second RN signature in violation of requirement for double check prior to blood transfusion.</td>
<td></td>
</tr>
<tr>
<td>New RN programs pump incorrectly because of inadequate orientation to pump and lack of availability of preceptor.</td>
<td>A housekeeper brings bleach from home and places it in her mop water in hopes of providing better cleaning and a fresher smell. She is assigned to clean up a spill of formaldehyde which has an adverse chemical reaction to the bleach in her mop water.</td>
<td>Physician has been reminded repeatedly regarding personal safe practices regarding hand washing but does not wash hands prior to examining patient.</td>
<td></td>
</tr>
<tr>
<td>A patient transporter misinterprets a location code and delivers a patient to OR instead of Interventional Radiology</td>
<td>An office employee passes sensitive patient information about a celebrity to the local newspaper, in strict violation of hospital policy.</td>
<td>An office employee passes sensitive patient information about a celebrity to the local newspaper, in strict violation of hospital policy.</td>
<td></td>
</tr>
</tbody>
</table>

*NOTE: OUTCOMES DO NOT PREDICATE HOW WE MANAGE BEHAVIORS*
| Definitions:                                                                 |                                                                 |
| AT-RISK BEHAVIOR – behavioral choice where risk is not recognized, or is mistakenly believed to be justified |
| COACHING – supportive discussion with the employee on the need to engage in safe behavioral choices          |
| COUNSELING – a first step disciplinary action; putting the employee on notice that performance is unacceptable |
| DISCIPLINARY ACTION – actions beyond remedial, up to and including punitive action or termination               |
| HUMAN ERROR – inadvertently doing other than what should have been done: a slip, lapse, mistake                  |
| IMPOSSIBILITY – condition outside of employee’s control that prevents duty from being fulfilled                  |
| KNOWINGLY – having knowledge that harm is practically certain to occur                                          |
| PERFORMANCE SHAPING FACTORS – Attributes that impact the likelihood of human errors or behavioral drift         |
| PUNITIVE ACTION – punitive deterrent to cause an individual or group to refrain from undesired behavioral choices |
| PURPOSE – conscious objective to cause harm                                                                   |
| RECKLESS BEHAVIOR – behavioral choice to consciously disregard a substantial and unjustifiable risk             |
| REMEDIAL ACTION – actions taken to aid employee including education, training, assignment to task appropriate to knowledge and skill |
| SUBSTANTIAL AND UNJUSTIFIABLE RISK – A behavior where the risk of harm outweighs the social benefit attached to the behavior |