SickKids	Document Scope: Hospital-wide Administration	
	Document Type: Policy; Procedure; Guideline Approved on 2013-05-24 Next Review Date: 2016-05-24	
	Management of Staff Involved in Healthcare Associated Harm: A Fair and Just Culture	Version: 1

1.0 Introduction

A "Fair and Just Culture" supports learning from unsafe acts that result in potential or real harm as a way to prevent future errors. It requires an atmosphere of trust in which people are encouraged and rewarded for reporting and providing safety information, but in which there is also clarity about accountability for acceptable and unacceptable behaviour (Reason, 1997). A fair and just culture strikes a balance between a punitive culture and a blame free culture. Differentiating acceptable from unacceptable behaviour associated with harmful events requires a consistent approach to determine culpability of individuals against system flaws that contribute to unsafe acts. More than one unsafe act by more than one individual can contribute to an event. For optimal learning and fair treatment of staff, each act should be considered individually using the same structured approach.

The following guideline will help to support a consistent and fair approach to the management of staff following events involving healthcare associated harm. It is based on the following premises:

- Health care is a complex and high risk activity prone to healthcare associated harm.
- Weak systems create the conditions for and the inevitability of human error.
- Latent conditions preceding adverse events include poor decisions, poor designs, poor supervision, inadequate tools and equipment, and the cumulative actions of individuals.
- Capturing, tracking and learning from healthcare associated harm is an essential step to safer care.
- A culture perceived as shaming, blaming and punishing of staff for unintentional harm is a major impediment to safety reporting and harm prevention

Disciplinary decision making related to healthcare associated harm is influenced by individual, organizational and societal perspectives and biases.
Too much emphasis on any single perspective can impede the aim to identify and to learn from error. A combination of perspectives must be considered.
Perspectives and biases to consider are:

- **Outcome-based discipline decisions** focus on the severity of the event and presume that more severe outcomes are more blameworthy. Outcome decisions must be considered under certain circumstances (e.g. legal reasons) but may bias discipline against those who intended no harm in a system prone to undesirable outcomes. When focused only on outcomes, reckless behaviour that results in no harm would be overlooked until harm occurs.
- **Rule-based discipline decisions** are prevalent in high risk work environments to promote reliability. When competing rules exist in complex situations, there may be valid reasons to violate one rule in favour of another when acting in the best interest of patients. Critical learning opportunities exist when variation from rules occurs. Automatic punishment may prevent the reporting of rule violations.
- **Risk-based discipline decisions** focus on individuals who knowingly take risks. The degree of culpability for risky behaviour depends on the individual's awareness that they were taking risks that could cause harm. An individual who takes risks but is unaware that they are doing so should not necessarily be disciplined in a fair and just culture.

2.0 Definitions

Healthcare Associated Harm is defined as an unexpected and undesired incident directly associated with the care or services provided to the patient (CPSI, 2008).

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Harm is defined as the negative affects on a patient's health and/or quality of life as a result of care and/or services provided (e.g. may require additional treatments or investigations or increased length of stay). Harm may be actual or potential.

3.0 Policy

At the Hospital for Sick Children (SickKids) staff involved in events resulting in actual or potential healthcare associated harm will be treated fairly, balancing the requirement for personal and professional accountability and the inevitability of human error due to latent system conditions which contribute to error.

4.0 Guideline

The following flow diagram outlines the considerations and questions which should be addressed in determining the treatment of staff involved in healthcare associated harm events. The decision process starts with the identification and root cause analysis of an actual or potentially harmful event. There are likely to be more than one action by one or more people contributing to an event resulting in harm. The decision tree should be applied separately to each action to support a fair and just culture. The tool should be initiated from a neutral position to determine fair and just management of all staff involved in events associated with harm.

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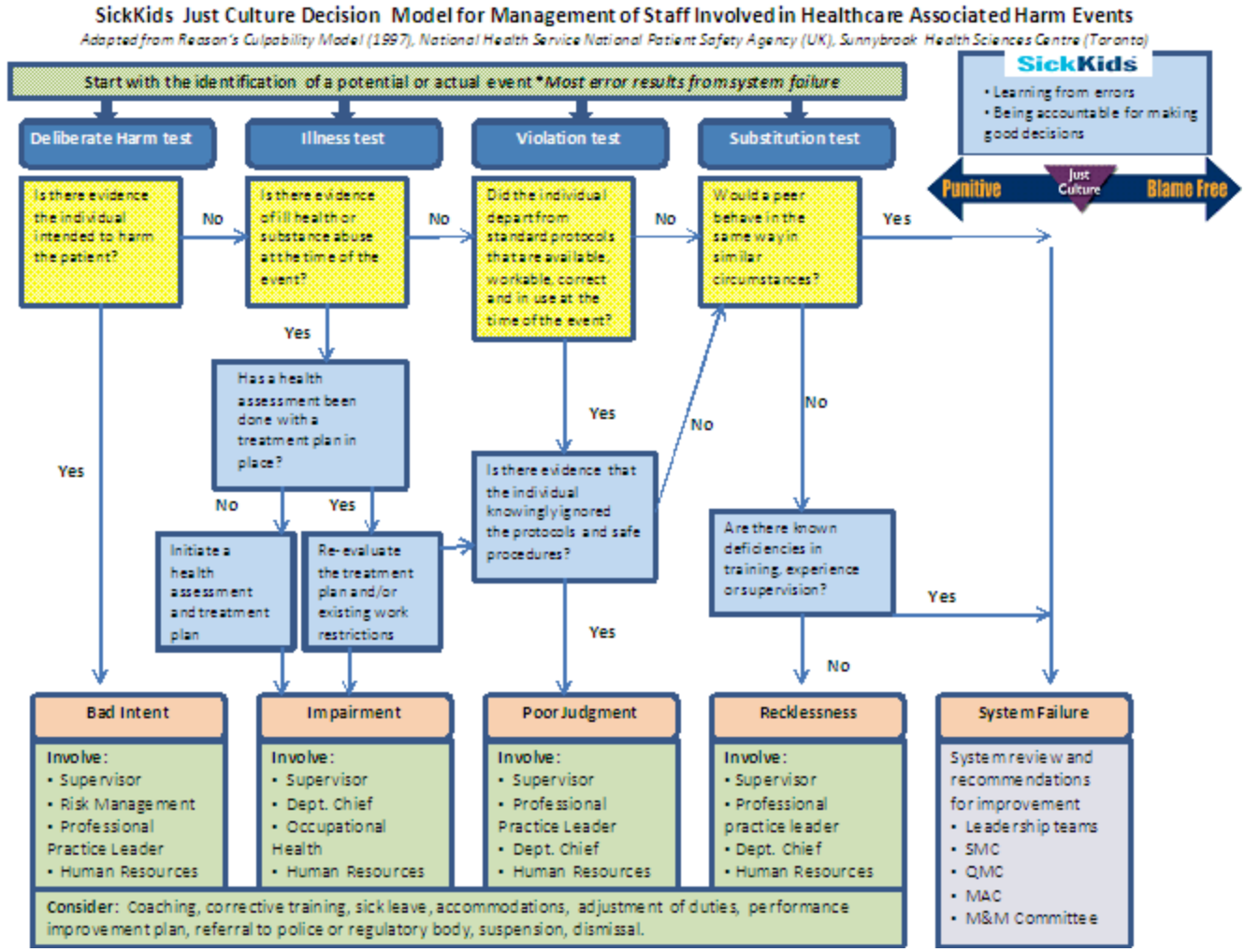

5.0 References

The Canadian Patient Safety Dictionary. The Canadian Patient Safety Institute. October, 2003.

Frankel, A., Leonard, M, Denham, C. Fair and Just Culture, Team Behaviour, and Leadership Engagement: the Tools to Achieve High Reliability. Health Serv Res. 2006 August; 41(4 pt 2): 1690-1709

Marx, David. Patient Safety and the "Just Culture": A primer for health care executives. Columbia University. 2001

The National Patient Safety Agency (NPCSA) Incident Decision Tree UK

Reason, J. Managing the risks of organizational accidents. London, Ashgate Publishing, 1997.

6.0 Related Policies

Management of Critical Occurrences ==>

Disclosure of Adverse Events ==>

Safety Reporting ==>

Mandatory Reporting of Regulated Health Professional ==>