# National Patient Safety Policy

## Just Culture Policy

# 2022

المركز السعودي لسلامة المرضى

SAUDI PATIENT SAFETY CENTER

## Introduction

Saudi Patient Safety Center (SPSC) recognizes the necessity to address the national need to standardize the just culture principles as a core component to improve patient safety and emphasizes that organizations need to balance systemic factors (system failures) alongside accountability for individual actions to achieve a consistent and fair approach to patient safety improvement and performance outcomes.

SPSC encourages all healthcare institutions to have policies and procedures that address Patient Safety Culture, including the Just culture principle.

## Acknowledgement

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## 1. POLICY STATEMENT

The policy intends to recommend a national Just-Culture framework and highly encourage healthcare institutions to build a culture in that all leaders and healthcare providers understand basic patient safety culture principles and develop a "Just- Culture" policy and procedures tailored to their needs and resources.

## 2. SCOPE

- The policy directive sets out the best practices and minimum requirements to maintain a Just- Culture among healthcare institutions .
- Legal and Disciplinary processes are outside the scope of this policy.
- The policy applies to all healthcare settings.

## 3. DEFINITIONS/ABBREVIATIONS

**Just - Culture**

A culture in which frontline personnel are comfortable disclosing errors, including their own, while maintaining professional accountability, recognizing individual practitioners should not be held accountable for system failings over which they have no control, yet does not tolerate conscious disregard of clear risks to patients or gross misconduct. (AHRQ definition)

**Response to Error**

The extent to which staff are treated fairly when they make mistakes and there is a focus on learning from mistakes and supporting staff involved in errors. (AHRQ definition)

**Reckless Behavior**

They are behavioral choices that are made when individuals have lost the perception of risk associated with the choice or mistakenly believe the risk to be insignificant or justified. (ISMP definition)

**Patient Safety Events**

Patient Safety event: is defined as any type of healthcare-related error, mistake, or incident, regardless of whether or not it results in patient harm. (AHRQ definitions)

**Second Victim**

Health care providers who are involved in an unanticipated adverse event, medical error, or patient injury and "become victimized in the sense that the provider is traumatized by the event". (AHRQ definition)

## 4. POLICY

- All healthcare institutions need to balance the response to errors by identifying system issues that lead to unsafe behaviors while maintaining individual accountability (i.e., establishing zero tolerance for reckless behaviors and ensuring that actions will be evaluated considering the circumstances and context of what occurred, rather than results and outcomes).

- All healthcare institutions need to utilize a proper just culture tool that guides a consistent, constructive, and fair evaluation of the actions of staff involved in patient safety events.

- Saudi Patient Safety Center (SPSC) encourages all healthcare organizations to utilize the adopted NHS Just- Culture guide. **(Attachment 1).**

- All healthcare institutions need to ensure the outcome of the evaluation of staff actions is documented, reviewed, archived, and dealt with confidentially.

- All healthcare institutions need to include and discuss "Just-Culture related" activities and lesson learned as a fixed agenda item in their relevant committee or structure (e.g., Quality and Patient Safety Committee).

- All healthcare institutions need to promote open communication culture (ability to disclose information about Patient Safety Events) by all who work, visit, or are cared for at the Institute.

- All healthcare institutions need to have a process for organizational learning (using what is learned from the Patient Safety Events to prevent future harm).

- All healthcare institutions leaders need to ensure that "Just -Culture" principles are implemented organization-wide.

- All healthcare organizations need to train leaders, patient safety workforce, and everyone at all levels of the organization on Just-Culture principle and tools.

- All healthcare institutions need to have a program for protection and support staff involved in patient safety events, (the second victim) as part of an integrated system for handling patient safety events and establishing a Just- Culture.

## 5. MONITORING PERFORMANCE MEASUREMENT

All health care institutions need to develop an internal performance improvement measure to monitor the implementation of the Just-Culture guide, which possibly includes a structure, process, and outcome measures.

**Suggested areas for monitoring:**

1. Just -Culture training completed for all staff (e.g., Percentage of staff completing Just - Culture training).

2. Compare and monitor the change over time of the patient safety culture survey results for the following:

   - The positive response of the Response to Error and, Communication Openness patient safety culture survey domains' results, nationally and at the facility level.
   - The number of the Events Reported item per staff category.

## 6. ATTACHMENTS

**Attachment (1)**
**Just - Culture guide**

**The soft copy of the guide is available in the below link:**

https://spsc.gov.sa/English/Pages/a-just-culture-guide.aspx

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# A just culture guide

## Supporting consistent, constructive, and fair evaluation of the actions of staff involved in patient safety incidents

This guide supports a conversation between managers about whether a staff member involved in a patient safety incident requires specific individual support or intervention to work safely. Action singling out an individual is rarely appropriate - most patient safety issues have deeper causes and require wider action.
The actions of staff involved in an incident should **not** automatically be examined using this *just culture guide*, but it can be useful if the investigation of an incident begins to suggest a concern about individual action. The guide highlightsimportant principles that need to be considered before formal management actionis directed at an individual staff member.

An important part of a just culture is being able to explain the approach that will be taken if an incident occurs. A just culture guide can be used by all parties to explain how they will respond to incidents, as a reference point for organizational HR and incident reporting policies, and as a communication tool to help staff, patients and families understand how the appropriate response to a member of staff involved in an incident can and should differ according to the circumstances in which an error was made. As well as protecting staff from unfair targeting, using the guide helps protect patients by removing the tendency to treat wider patient safety issues as individual issues.

**Please note:**

- **A just culture guide is not a replacement for an investigation of a patient safety incident. Only a full investigation can identify the underlying causes that need to be acted on to reduce the risk of future incidents.**
- **A just culture guide can be used at any point of an investigation, but the guide may need to be revisited as more information becomes available.**
- **A just culture guide does not replace HR advice and should be used in conjunction with organizational policy.**
- **The guide can only be used to take one action (or failure to act) through the guide at a time. If multiple actions are involved in an incident they must be considered separately.**

## Start here - **Q1. deliberate harm test**

**1a.** Was there any intention to cause harm?

Yes — **Recommendation:** Follow organizational guidance for appropriate management action. This could involve contact relevant regulatory bodies, suspension of staff, and referral to police and disciplinary processes. Wider investigation is still needed to understand how and why patients were not protected from the actions of the individual. — END HERE

## No go to next question - **Q2. health test**

**2a.** Are there indications of substance abuse?

Yes — **Recommendation:** Follow organizational substance abuse at work guidance. Wider investigation is still needed to understand if substance abuse could have been recognized and addressed earlier. — END HERE

**2b.** Are there indications of physical ill-health?

**2c.** Are there indications of mental ill-health?

Yes — **Recommendation:** Follow organizational guidance for health issues affecting work, which is likely to include occupational health referral. Wider investigation is still needed to understand if health issues could have been recognized and addressed earlier. — END HERE

## if No to all go to next question - **Q3. foresight test**

- **Manage through changes in choices, processes, procedures, training, design, and environment**.

**3a.** Are there agreed protocols/accepted practices in placethat apply to the action/omission in question?

**3b.** Were the protocols/accepted practice workable and in routine use?

**3c.** Did the individual knowingly depart from these protocols?

If No to any — **Recommendation:** Action singling out the individual is unlikely to be appropriate; the patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. These actions may include, but not be limited to, the individual. — END HERE

## if Yes to all go to next question - **Q4. substitution test**

**4a.** Are there indications that other individuals from the same peer group, with comparable experience and qualifications, would behave in the same way in similar circumstances?

**4b.** Was the individual missed out when relevant training was provided to their peer group?

**4c.** Did more senior members of the team fail to provide supervision that normally should be provided?

If Yes to any — **Recommendation:** Action singling out the individual is unlikely to be appropriate; the patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. These actions may include, but not be limited to, the individual. — END HERE

## if No to all go to next question - **Q5. mitigating circumstances**

**5a.** Were there any significant mitigating circumstances?

Yes — **Recommendation:** Action directed at the individual may not be appropriate; follow organizational guidance, which is likely to include senior HR advice on what degree of mitigation applies. The patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. — END HERE

## if No

**Recommendation:** Follow organisational guidance for appropriate management action. This could involve individual training, performance management, competency assessments, changes to role or increased supervision, and may require relevant regulatory bodies to be contacted, staff suspension and disciplinary processes. The patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. — END HERE

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## 7. REFERENCES

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