Just Culture Guide

An Stiúrthóireacht um Ardchaighdeáin agus Sábháilteacht Othar
Oifig an Phríomhoifigigh Chliniciúil

National Quality and Patient Safety Directorate
Office of the Chief Clinical Officer

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

The purpose of the Just Culture Guide is to support a conversation between managers about whether a staff member involved in a patient safety incident requires specific individual support or intervention to work safely. The actions of staff involved in an incident should <u>**not**</u> be routinely examined using the Just Culture Guide, but it can be useful if, in the course of managing or reviewing an incident, there is suggestion of a concern about the actions of an individual. The Just Culture Guide highlights important principles that need to be considered before formal management action is directed towards an individual staff member. The approach does not seek to diminish the individual accountability of a health care professional, but encourages key decision makers to consider systems and organisational issues in the context of the management of error. Action singling out an individual is rarely appropriate – most patient safety issues have deeper causes and require wider action.

- A just culture guide is not a replacement for a review of a patient safety incident. Only a review carried out in line with the IMF 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 in a review, but 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 organisational 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.

Question	Answer	Recommendation	
Start here – Q1. deliberate harm test			
1a. Was there any intention to cause harm?	Yes	**Recommendation**: Follow organisational guidance for appropriate management action. This could involve: contact relevant regulatory body, suspension of staff, referral to Gardaí and disciplinary processes. Wider review is still needed to understand how and why service users were not protected from the actions of individuals.	End Here
If **No,** go to next question **– Q2. health test**			
2a. Are there indications of substance abuse?	Yes	**Recommendation:** Follow HSE Policy and Procedure on the Management of Intoxicant Misuse. Wider review is still needed to understand if intoxicant abuse could have been recognised and addressed earlier.	End Here
2b. Are there indications of physical ill-health? **2c.** Are there indications of mental ill-health?	Yes	**Recommendation:** Follow HSE policy for health issues affecting work e.g. Managing Attendance Policy and Rehabilitation of employees back to work after injury or illness policy, and the need to make a referral to occupational health. Wider review is still needed to understand if health issues could have been recognised and addressed earlier.	End Here
If **No to all** go to the next question **– Q3. foresight test**			
3a. Are there agreed protocols/accepted practice in place that applies 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 review 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 the 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 review should indicate the wider actions needed to improve safety for further patients. These actions may include, but not be limited to, the individual.	End Here
If **No to all** go to the next question – **Q5. mitigating circumstances**			
5a. Were there any significant mitigating circumstances?	Yes	**Recommendation:** Action directed at the individual may not be appropriate; follow organisational guidance, which is likely to include senior HR advice on what degree of mitigation applies. The patient safety incident review should indicate the wider actions needed to improve safety for future service users.	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 review should indicate the wider actions needed to improve safety for future patients.			End

Extracted from the HSE Incident Management Framework (available at https://www.hse.ie/eng/about/who/nqpsd/qps-incident-management/)

Adapted from NHS Improvement (UK) with permission.