Just Culture
Organisational commitment to a just culture
High quality Investigations (with learning for safety as the goal)
Critically reviewing, sharing and acting on recommendations
Fair and supportive treatment of staff, patients and families/carers
1
The organisation's commitment to a Just Culture is evident to staff from the very beginning of their employment and to patients from the start of their care
2
Policies are aligned across the organisation and actively support the Just Culture agenda with full consideration of the health and wellbeing of staff and patients.
3
Everyone knows what should be reported as a patient safety incident and what happens after incidents are reported, including support for staff, patients and their family/carers.
4
Risk management, patient safety, clinical, HR and OD teams work together to enact the policies and practices which support a Just Culture.
5
A patient safety incident is regarded as an opportunity for learning how to continuously improve as opposed to a failure or crisis. The organisation emphasises the purpose of incident reporting is to learn and not to monitor quality and safety.
6
The 'A just culture guide' is referred to when conducting patient safety incident investigations.
7
Patient safety incident investigations are decoupled from the line management function to avoid the investigation being perceived as a performance review.
8
Opportunities are sought during the investigation to learn about how things normally work in a department/unit rather than purely focusing on what went wrong.
9
Investigators understand the evidence about what constitutes strong (more likely to be effective and sustainable) and weak recommendations (not likely to inform practice or process improvements) following investigations.
10
Involving patient and family/carers as respected partners in the investigation and honouring their experiences are recognised as integral to achieving high quality investigations, learning and healing.
11
There is an acknowledgement that blanket recommendations to retrain staff after a patient safety incident are unlikely to make any difference.
12
When faced with situations that might compromise patient safety (such as where rules and reality clash), ways of flexing and adapting are continuously sought.
13
Systems are in place to monitor the carrying out of the recommendations from investigations in line with PSIRF (Patient Safety Incident Response Framework) to ensure that learning from patient safety incidents has a genuine positive and lasting impact on care.
14
Mechanisms exist for sharing information about recommendations and wider learning both within the organisation and across the system.
15
A clear strategy exists for debriefing all those involved in a patient safety incident (including patient, their family/carers, staff, teams) and describes how they will be involved in any investigation arising.
16
Staff are actively supported to disclose a patient safety incident to the patient and family/carers.
17
A clear plan exists for supporting staff as well as patients and their family/carers who have been involved in a patient safety incident.
18
Measures are taken to prevent those involved in a patient safety incident being stigmatised (e.g. healthcare professionals stigmatised as incompetent, unprofessional, unable to cope, a bad nurse/doctor/allied health professional; or patients and their family/ carers being stigmatised for being critical, making complaints or taking legal action).
19
In the aftermath of a patient safety incident or failure, penalties (financial, reputational, professional, and disciplinary) are avoided in almost all circumstances.
20
Feedback is sought from staff, patients and their family/carers about their treatment when involved in patient safety incidents.
21
Staff are provided with opportunity and support to gain and share wisdom to facilitate their own recovery following involvement in a patient safety incident.