# Our Commitment to Safety Fair and Just Culture Decision Guide

Applies to consulting and administrative voting staff, allied health and non-allied health

## What is a Fair and Just Culture?

It is an organizational culture:
- Where employees who make errors or witness errors feel safe disclosing them.
- Where employees aren’t fearful of a punitive response when human error occurs.
- Where the emphasis is on learning from mistakes and using the knowledge gained to reduce or eliminate similar errors in the future.
- Where an acknowledgement is made that well intended systems (processes/policies/procedures/guidelines) can be faulty and lead to errors.

## What are the advantages of a Fair and Just Culture approach?

- An environment exists whereby incidents/errors are brought forward more readily without the fear of punitive action.
- When errors occur, fair and just responses leading to changes that effectively reduce or eliminate the potential for future errors.

## Step 1 – Investigate if the choice was Human Error. Was an inadvertent action, slip, lapse, or mistake made? If no, proceed to step 2

<table>
<thead>
<tr>
<th>Recommendation (Individual)</th>
<th>Recommendation (System)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learn what happened. Console the individual. Provide training if applicable.</td>
<td>Learn whether others are making the same inadvertent actions, slips, lapses or mistakes. Evaluate the policy/procedure/guideline at the appropriate level (team, unit, department, division, organization, etc.) The investigation may indicate that wider actions are needed to improve safety for future patients.</td>
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## Step 2 – Investigate if the choice was Risky (drift) Behavior. Was a behavioral choice made that increases risk where risk is not recognized or is mistakenly believed to be justified? If no, proceed to step 3

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<td>Learn from the individual why they made the choice. Why did the individual knowingly depart from the policy/procedure/guideline? Did the individual receive relevant training? Coach the individual to follow established policies/procedures/guidelines.</td>
<td>Learn whether others are making this choice. Was the policy/procedure/guideline in routine use on the unit? Are ‘work arounds’ the norm? Are the processes workable? Evaluate policy/procedure/guideline at the appropriate level (team, unit, department, division, organization, etc.) The investigation may indicate that wider actions are needed to improve safety for future patients.</td>
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## Step 3 – Investigate if the choice was Reckless Behavior. Was a behavioral choice made or policy/procedure/guideline not followed where risk was consciously disregarded or unjustifiable?

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<td>Learn about what happened from the individual. It may be appropriate to utilize one of the more advanced steps in the corrective action process for the employee.</td>
<td>Wider investigation is still needed to understand how and why a patient was not protected from the actions of the individual. Was there opportunity for a colleague to speak up and it did not occur, find out why?</td>
</tr>
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Supervisors/managers partner with their direct supervisor/administrator and Human Resource Advisors to work through these decisions.