Emergency Operations – 100.36		
S.O.P. # 100.36	**Adverse Events**	PAGE: 1 OF 16
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100.36.01 Purpose

This policy provides guidelines on how adverse events are to be investigated, how responses to investigation outcomes should be determined and what kind of supportive documentation should be utilized. It is recognized that the *Just Culture©* model provides a methodology for engaging these tasks. Organizations that deploy a *Just Culture©* philosophy can expect to reap a number of benefits including:

- Provides an objective and consistent process for evaluating employee choices.
- Prioritizes the identification of behavioral choices and system designs that contain risk and allows for the development of strategies to manage that risk.
- Targets response to behavioral choices that evaluate for root cause thereby increasing the likelihood that future occurrences will be avoided.
- Creates a system of transparency that allows for employees to be held accountable for their choices but provides them with a sense of fairness and due process.

100.36.02 General Overview

Just Culture© is a system of shared accountability in which the Charles County Department of Emergency Services is accountable for the system it has designed and for responding to the behavior of its employees in a fair and just manner. Employees, in turn, are accountable for the quality of their choices and for reporting both their errors and system vulnerabilities.

Just Culture is based upon a shared belief in the following principles.

- It is impossible to design a system that is perfect and does not allow for undesirable outcomes.
- All employees at every level will commit errors. It is unavoidable.
- All employees will drift into at-risk behavior as they become more experienced and confident with their jobs. As their comfort with activities grow, the perceived risks associated with those activities begin to fade.
- The best systems anticipate human error and at-risk behavior and are designed to predict where those failures will occur and to manage them before they can cause harm.
- *Just Culture©* philosophy works best in a learning environment that seeks to learn from our mistakes and to share what we learn in an effort to support continued safe choices and system improvements.

- The most effective systems productively coach employees around reliable behaviors and recognize when remedial or disciplinary action will best serve the organization.

100.36.03 Definitions

At-Risk Behavior – behavioral choice that increases risk where risk is not recognized, or is mistakenly believed to be justified.

Coaching – a values supportive discussion with the employee on the need to engage in better behavioral choices

Counseling – a first step in disciplinary action; putting the employee on notice that performance is unacceptable

Disciplinary Action – actions beyond remediation, up to and including punitive action or termination

Human Error – inadvertently doing other than what was intended

Knowingly Cause Harm – having knowledge that harm is practically certain to occur

Performance Shaping Factors – attributes that impact the likelihood of human errors or behavioral drift; examples include heavy call volume, reflex time requirements, and irregularly scheduled vehicle maintenance

Personal Performance Shaping Factors – attributes that impact the likelihood of human errors or behavioral drift that are personal in nature; examples include poor health or illness, stress, marital problems and drug/alcohol addiction

Reckless Behavior – behavioral choice to consciously disregard a substantial and unjustifiable risk

Remedial Action – actions taken to aid the employee including education, training and re-assignment

Substantial and Unjustifiable Risk – a behavioral choice where the risk of harm outweighs the social benefit attached to the behavior

100.36.04.01 Event Investigation

It is necessary that some type of event investigation occurs for each separate adverse event or trend. But just as every event differs in scope and severity, so will the methodologies employed in each investigation differ to some degree. Some events will dictate rigorous and formal investigations while less serious ones will demand a more informal approach. In any case, however, there are certain steps that may prove beneficial or even essential to each review.

1. Identify the undesirable outcome.
    a. This may be expressed in terms of harm to person or property or it may be determined that it was a precursor event that held the potential for harm.
    b. Always look for multiple undesirable outcomes as there may be different causes to each. For example, an accident in which a provider or patient was injured might have two undesirable outcomes – damage to the vehicle and injury to a person. The cause of the vehicle damage might include a failure to stop in time but the injury to the person although attributed to the accident might have resulted more directly from a failure to wear a safety harness.
    c. All adverse events concerning patient care must be forwarded to the Quality Assurance Officer for handling.
2. Search for causes
    a. Determine what happened.
    b. Determine what normally happens.
    c. Determine how policy, protocols or standards of care might relate to the event.
3. Build a cause and effect diagram. (See Fig. 1)
    a. Start at the left with the undesirable outcome and work rightward until you have reached what you perceive to be the root cause of the event.
    b. This process is more appropriate for more formal investigations but may prove useful in the review of more minor issues when root cause is not obvious.
4. Explain all human error, knowing violations or mechanical failures. Each of these events will have a cause.

100.36.04.02 Just Culture Algorithm

1. All adverse events should be evaluated using the appropriate *Just Culture Algorithm©* which is designed to evaluate behavioral choices and determine whether an employee's decisions should be attributed to human error, at-risk behavior or reckless behavior.
2. Determine which algorithm to use.
    a. Did the employee fail to follow a rule designed by the employer? If so, follow the ***Duty to Follow a Procedural Rule*** algorithm. (fig. 2)
    b. Did the employee fail to produce an outcome expected by the employer? If so, follow the ***Duty to Produce an Outcome*** algorithm. (fig. 3)

c. Did an employee put an organizational interest or value in harm's way? Was there harm or potential for harm to person or property? If so, follow the ***Duty to Avoid Causing an Unjustifiable Risk or Harm*** algorithm. (fig. 4)

3. Responding to the *Just Culture Algorithm ©*
    a. After conducting an event investigation and applying the *Just Culture Algorithm ©* to the employee's behavior and the system's design, you should be able to determine if the employee's behavior was simple error, at-risk or reckless. This determination will dictate your response.
    b. For human error, you should console the employee and evaluate the error for its root cause.
    c. For at-risk behavior, you should coach the employee and evaluate the at-risk behavior for its root cause.
    d. For reckless behavior, you should consider remedial or punitive action.
    e. Disciplinary Action
        i. All disciplinary action must be in accordance with Chapter 10 of the Charles County Government Personnel Policy and Procedure Manual.
        ii. Disciplinary action should begin with counseling in most instances. Although there may be times when proceeding straight to punitive action will be appropriate, it should be the exception and not the norm.
4. Generate solutions
    a. Evaluate system design and modify system performance shaping factors.
    b. Evaluate employee behavior and consider remedial action or note personal performance shaping factors.
5. Evaluate repetitive behaviors
    a. Algorithms exist for evaluating repetitive human errors (fig. 5) and repetitive at-risk behavior (fig. 6) and these should be applied when needed.
    b. Even when behavior is repetitive, system design and employee choices should be evaluated for identifiable performance shaping factors and action should be taken to modify these factors when possible.
    c. It is acknowledged that repetitive behavior, even when it is human error, may at times need to be addressed with disciplinary action including possible termination.

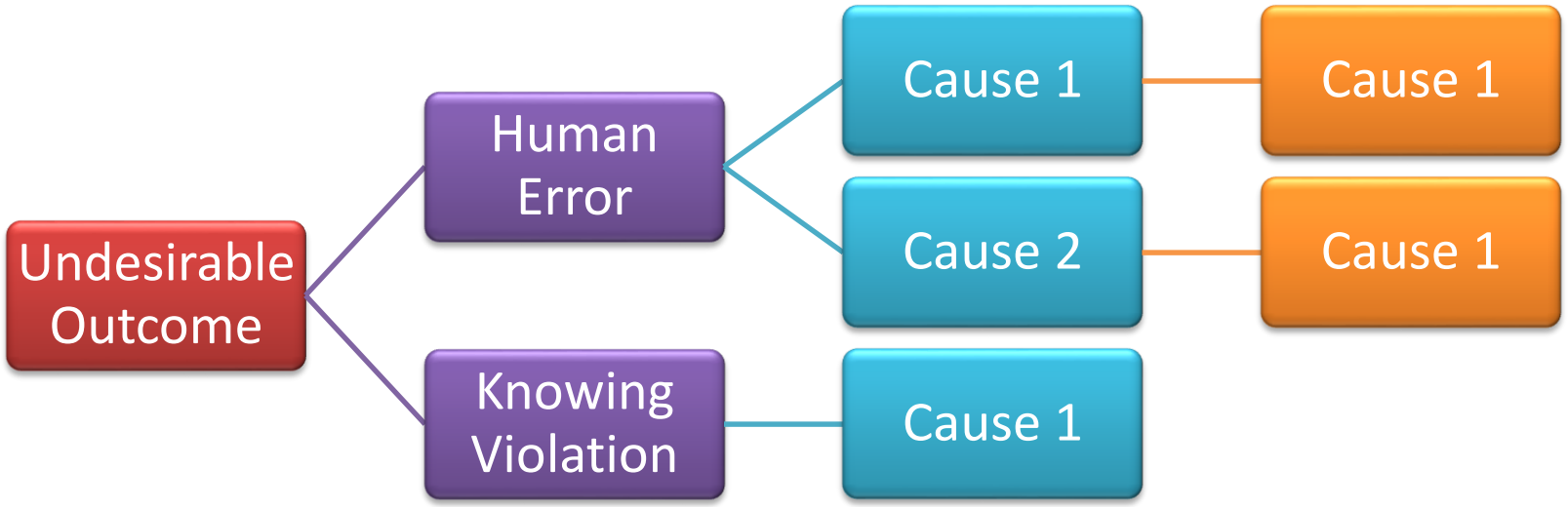
100.36.04.03 Documentation

1. Not all behavior or events will be considered significant enough for investigation or for the application of the *Just Culture Algorithm ©* It is appropriate to approach the employee in an informal manner when the errors are considered insignificant even at times when the behavior is repetitive. The documentation of mileage on patient care reports for example is a documentation requirement and the failure of an employee to include it in their reporting is a failure to meet that requirement. It would be most appropriate

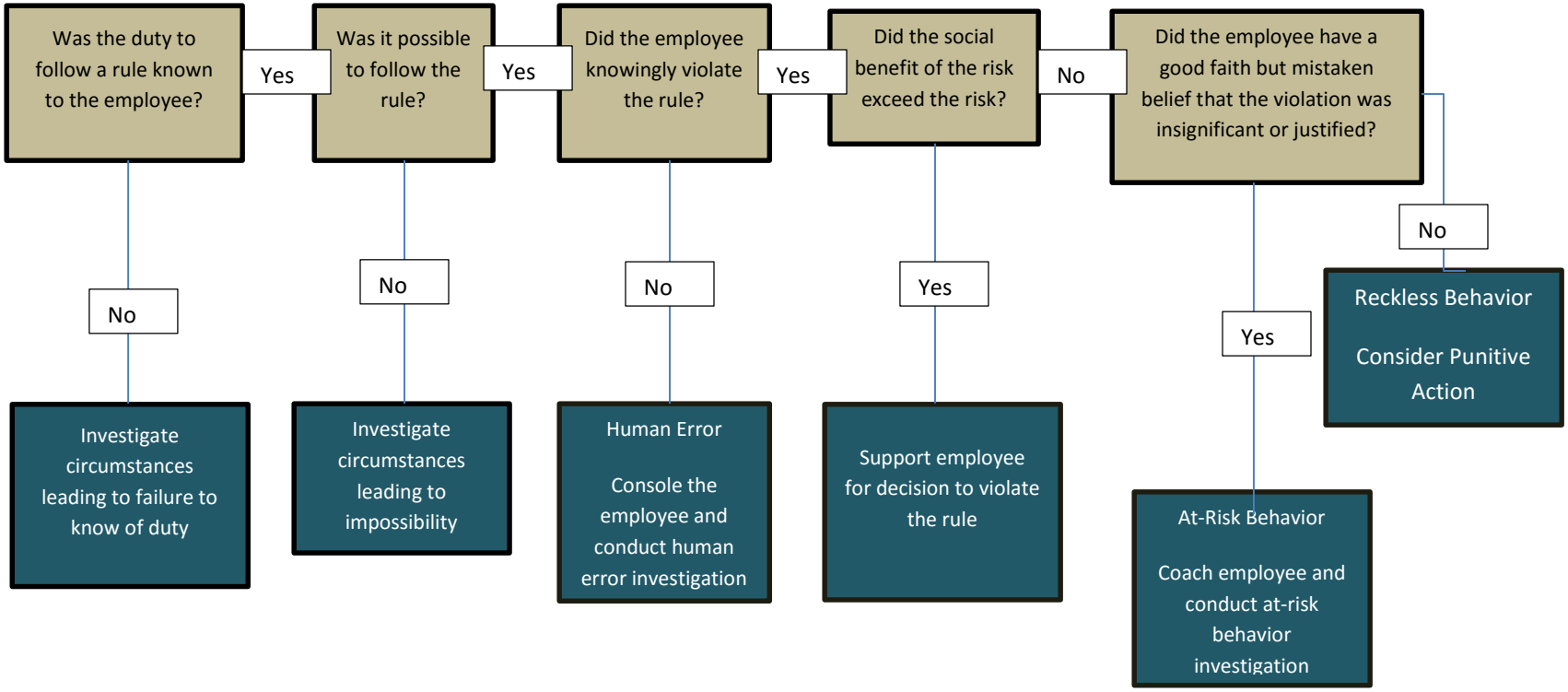
however for supervisors to remind the employee of this requirement perhaps multiple times before deciding to approach the employee in a more formal way. Once you determine that a more formal discussion needs to take place, this is when the *Just Culture Algorithm* © should be applied and this is when documentation *must* take place.

2. Prior to formal documentation, supervisors should be encouraged to make written notes in Staff Files or the eMEDS notification system as needed. These forms of notation serve as important barometers to an employee's behavior and will help you decide when to engage in more formal reviews.
3. When conducting an investigation, the appropriate *Adverse Event Form* must be used. Not all sections should be considered necessary in all instances. For example, you may elect not to use the Cause-and-Effect worksheet when investigating minor events.
4. An *Employee Conference Form* must be completed and signed by the employee when:
    a. The employee was found to have breached a duty of which they had no knowledge.
    b. Coaching around at-risk behavior
    c. Consoling of employee includes plans on how to make better behavioral choices in order to avoid future errors
    d. Consoling or coaching of employee includes referral to the Employee Assistance Program
    e. An employee is found to have engaged in Reckless Behavior
    f. An employee engages in repetitive at-risk behavior or commits repetitive errors, indicates that they understand the risks involved and is unwilling or unable to modify their behavior
5. Any disciplinary action taken or recommended beyond counseling must be documented on a Charles County Government Departmental Memo and should be forwarded to Human Resources through the supervisor's chain of command.

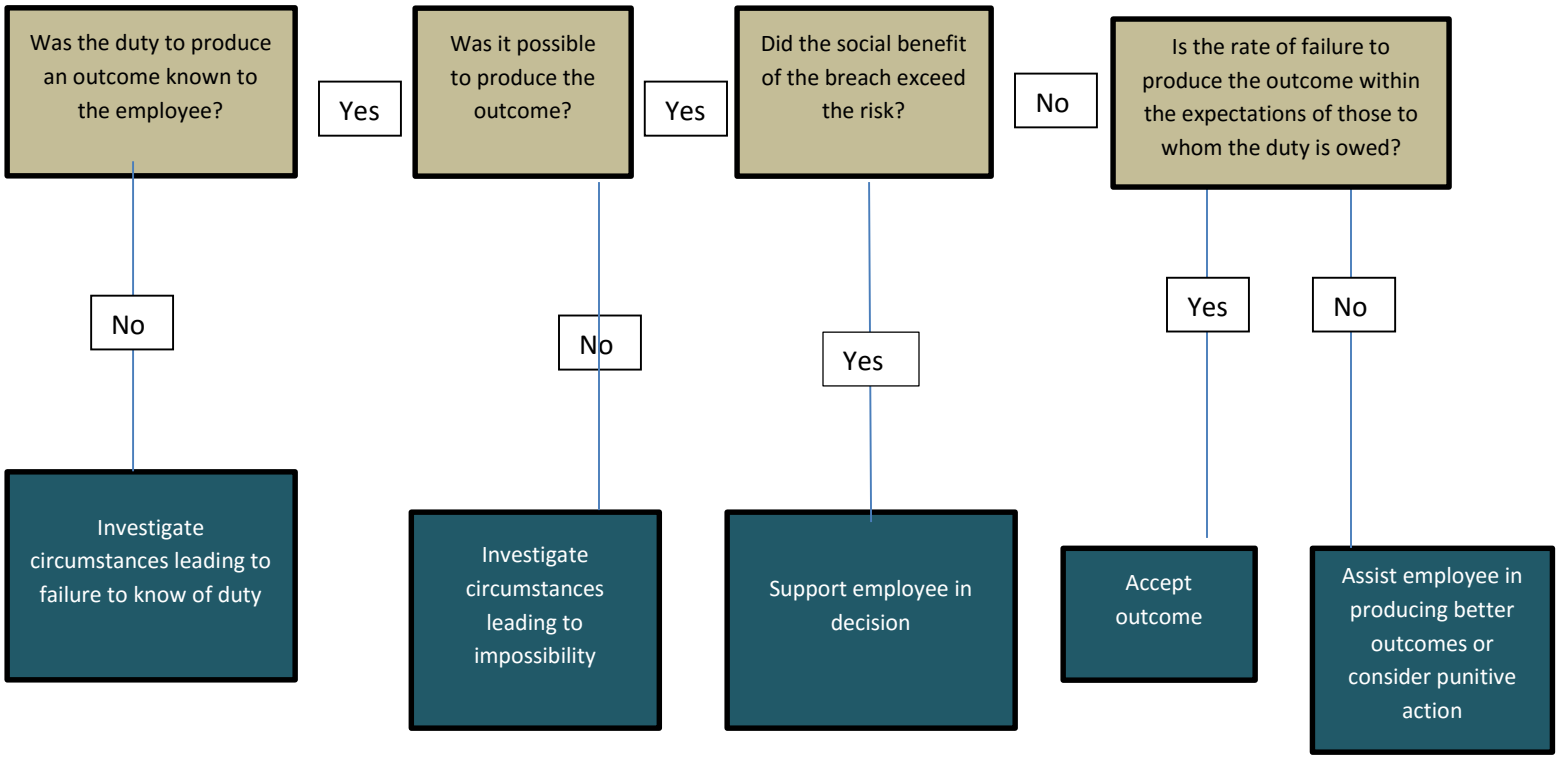
CAUSE AND EFFECT DIAGRAM – Figure 1



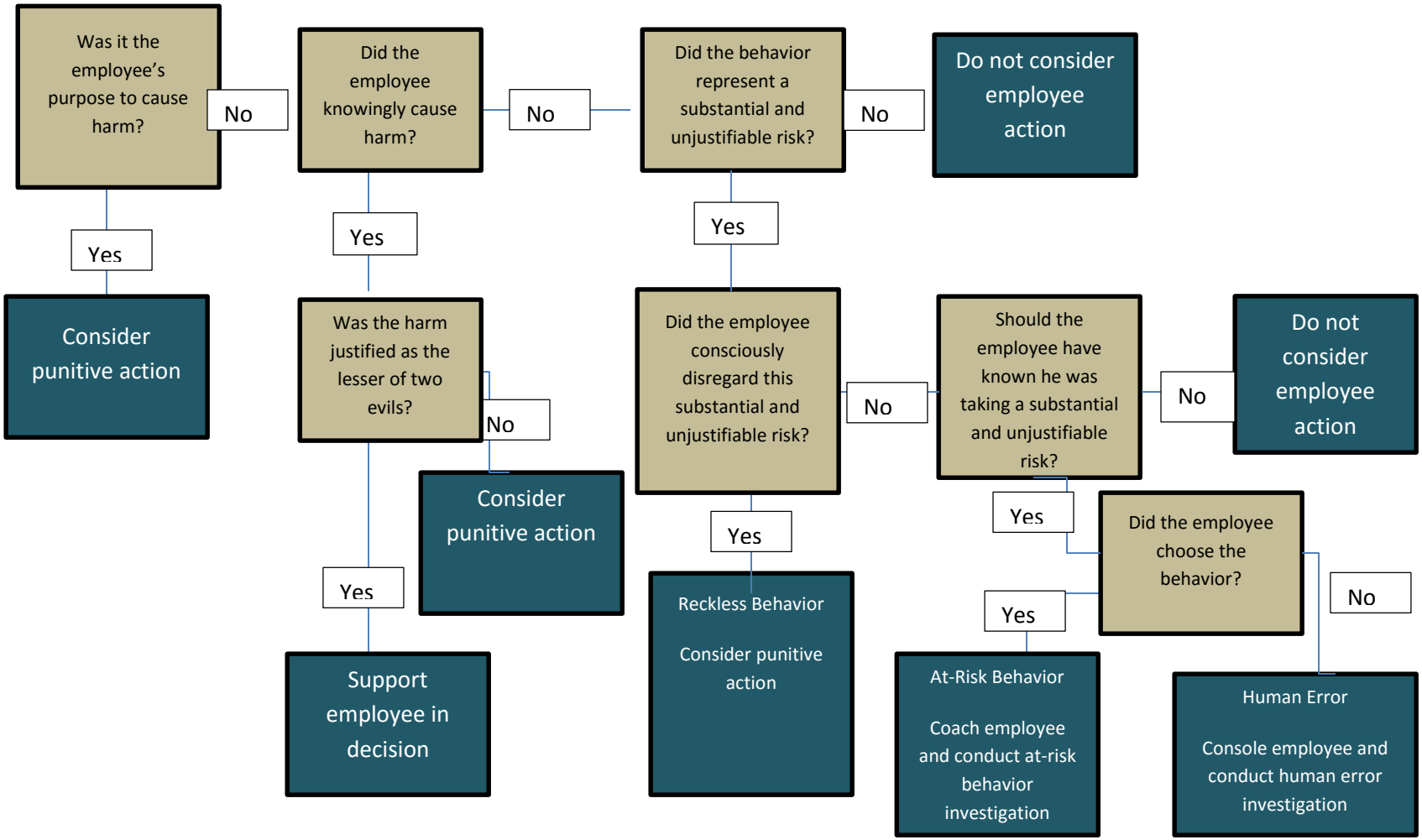
DUTY TO FOLLOW A PROCEDURAL RULE – Figure 2



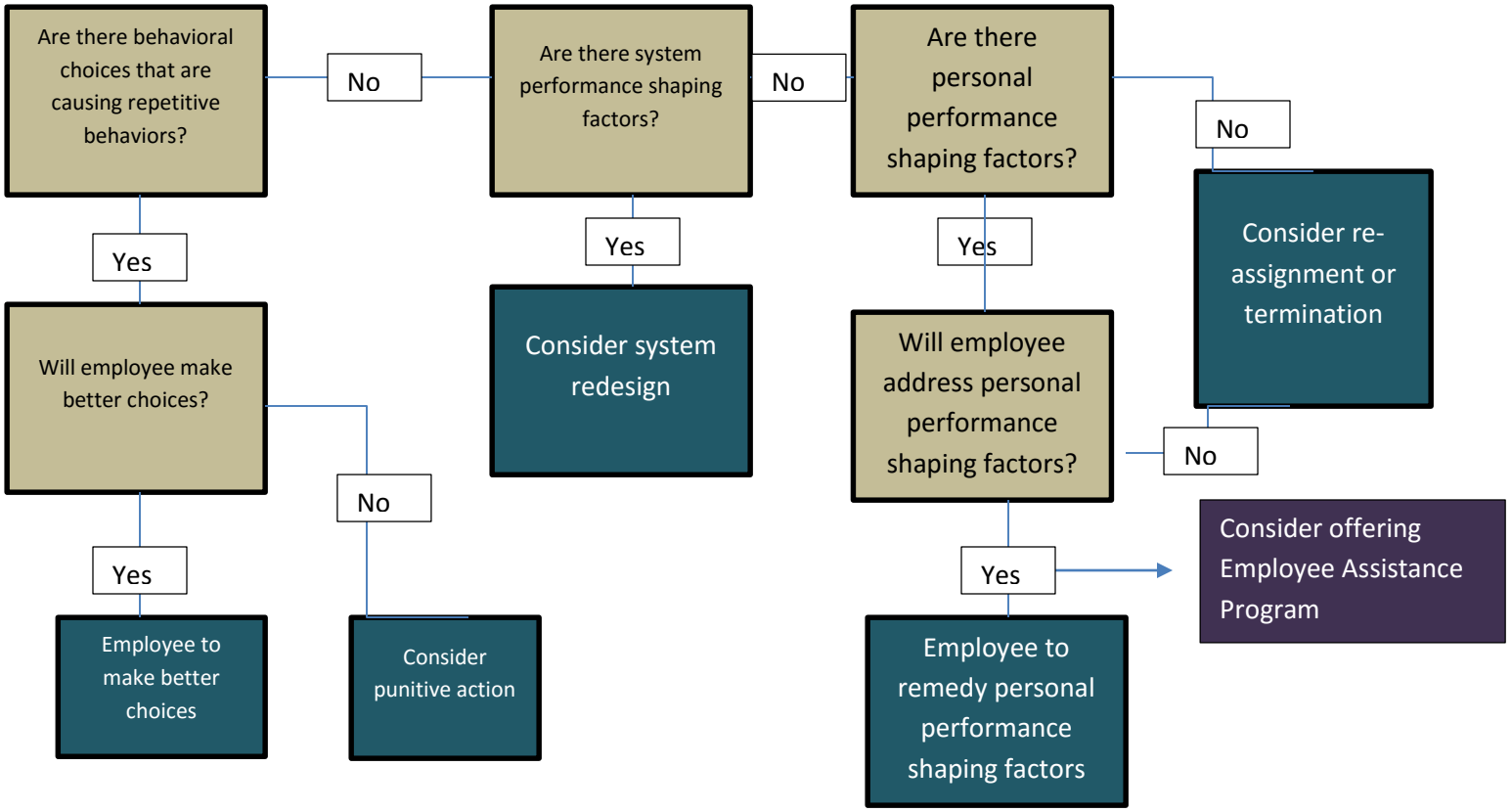
DUTY TO PRODUCE AN OUTCOME – Figure 3



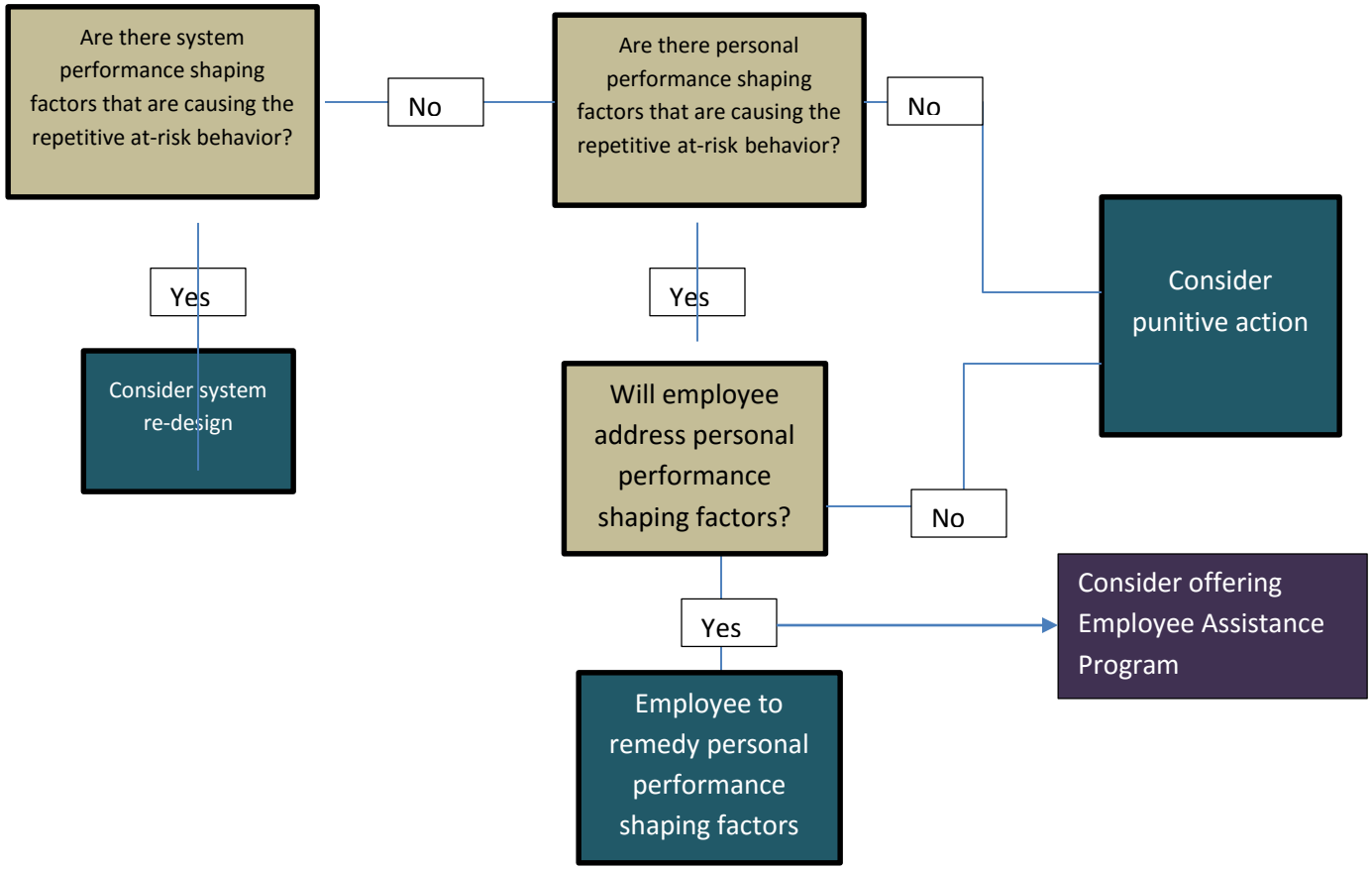
DUTY TO AVOID CAUSING UNJUSTIFIABLE RISK OR HARM – Figure 4



REPETITIVE HUMAN ERRORS – Figure 5



REPETITIVE AT-RISK BEHAVIORS – Figure 6



ADVERSE EVENT FORM - Duty to Follow a Procedural Rule

Employee Name		**Supervisor Name**	
Event Date		**Procedure or Policy Violated**	

Description of Adverse Event (Brief Description of Adverse Outcome, What Happened and Root Cause)

Algorithm Analysis

Question	Yes	No
Was the duty to follow a rule known to the employee?		
Was it possible to follow the rule?		
Did the employee knowingly violate the rule?		
Did the social benefit of the breach exceed the risk?		
Did the employee have a good faith but mistaken belief that the violation was insignificant or justified?		

Type of Behavior	Response to Behavior
☐ No Fault (Did not know of procedure, impossible to follow the procedure) ☐ Human Error ☐ At-Risk Behavior ☐ Reckless Behavior	☐ None ☐ Console ☐ Coaching ☐ Counseling ☐ Disciplinary Action ☐ EAP Recommended

System Design – Note any perceived problems with performance shaping factors that exist within the system and recommendations on how to modify these factors for risk reduction.

Supervisor Comments

ADVERSE EVENT FORM - Duty to Produce an Outcome

Employee Name		**Supervisor Name**	
Event Date		**Outcome Expected**	

Description of Adverse Event (Brief Description of Adverse Outcome, What Happened and Root Cause)

Question	Yes	No
Was the duty to produce an outcome known to the employee?		
Was it possible to produce the outcome?		
Did the social benefit of the breach exceed the risk?		
Is the rate of failure to produce the outcome within the expectations of those to whom the duty is owed?		

Type of Behavior	Response to Behavior
☐ No Fault (Did not know of procedure, impossible to follow the procedure) ☐ Human Error ☐ At-Risk Behavior ☐ Reckless Behavior	☐ None ☐ Console ☐ Coaching ☐ Counseling ☐ Disciplinary Action ☐ EAP Recommended

System Design – Note any perceived problems with performance shaping factors that exist within the system and recommendations on how to modify these factors for risk reduction.

Supervisor Comments

ADVERSE EVENT FORM - Duty to Avoid Causing Unjustifiable Risk or Harm

Employee Name		**Supervisor Name**	
Event Date			

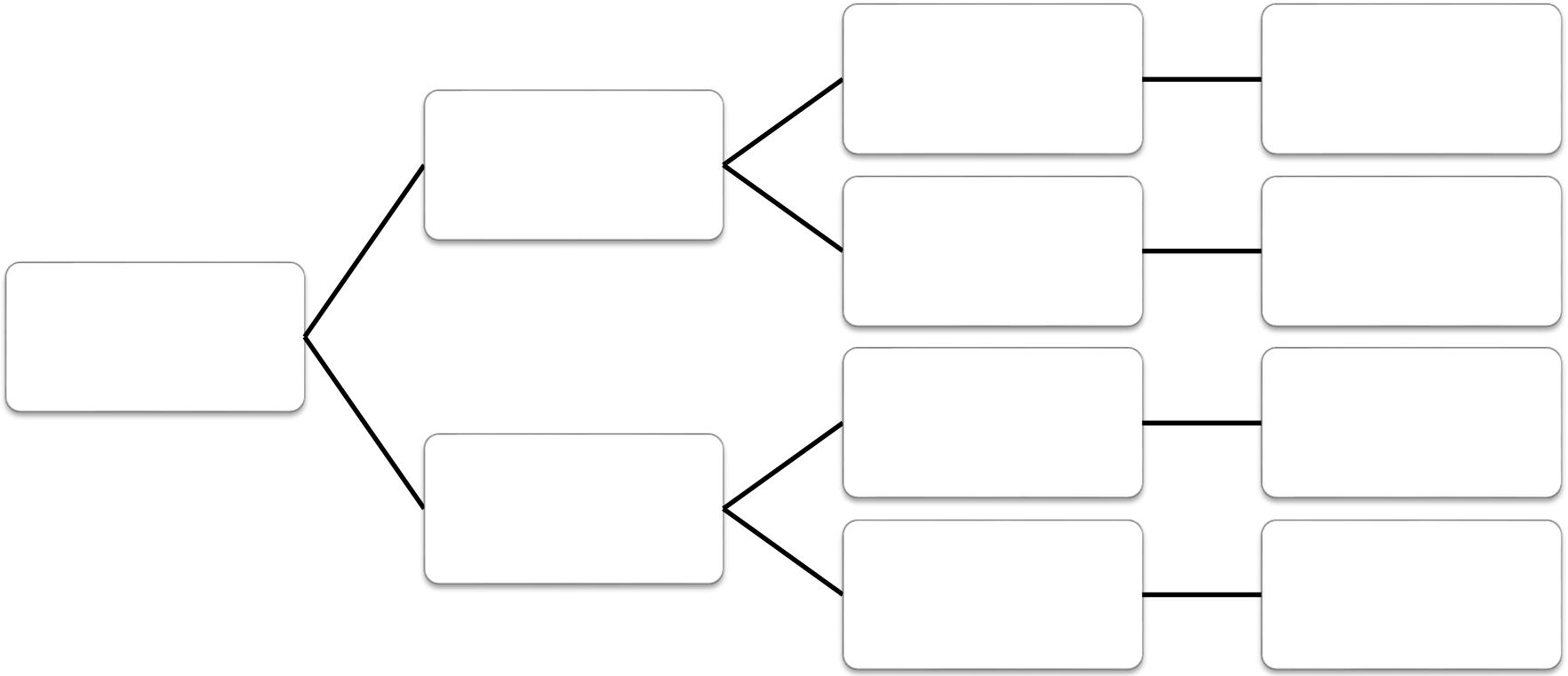
Description of Adverse Event (Brief Description of Adverse Outcome, What Happened and Root Cause)

Question	Yes	No
Was it the employee's purpose to cause harm?		
Did the employee knowingly cause harm?		
Was the harm justified as the lesser of two evils?		
Did the behavior represent a substantial and unjustifiable risk?		
Did the employee consciously disregard this substantial and unjustifiable risk?		
Should the employee have known he was taking a substantial and unjustifiable risk?		
Did the employee choose the behavior?		

Type of Behavior	Response to Behavior
☐ No Fault (Did not know of procedure, impossible to follow the procedure) ☐ Human Error ☐ At-Risk Behavior ☐ Reckless Behavior	☐ None ☐ Console ☐ Coaching ☐ Counseling ☐ Disciplinary Action ☐ EAP Recommended

System Design – Note any perceived problems with performance shaping factors that exist within the system and recommendations on how to modify these factors for risk reduction.

Supervisor Comments



Cause and Effect Worksheet

ADVERSE EVENT FORM - Duty to Follow a Procedural Rule (SAMPLE)

Employee Name	Chuck Brown	**Supervisor Name**	Stephen Smith
Event Date	August 2, 2016	**Procedure or Policy Violated**	401.01 Vehicle Operations – Use spotter while backing

Description of Adverse Event (Brief Description of Adverse Outcome, What Happened and Root Cause)

EMT Brown was noted backing up his ambulance at the Chick-Fil-A in La Plata while not using a spotter. When questioned, EMT Brown stated that he typically backs up without a spotter as his ambulance is equipped with a back-up camera and he feels that using a spotter would be redundant.

Question	Yes	No
Was the duty to follow a rule known to the employee?	**X**	
Was it possible to follow the rule?	**X**	
Did the employee knowingly violate the rule?	**X**	
Did the social benefit of the breach exceed the risk?		**X**
Did the employee have a good faith but mistaken belief that the violation was insignificant or justified?	**X**	

Type of Behavior

- ☐ **No Fault (Did not know of procedure, impossible to follow the procedure)**
- ☐ **Human Error**
- ☐ **At-Risk Behavior**
- ☐ **Reckless Behavior**

Response to Behavior

- ☐ **None**
- ☐ **Console**
- ☐ **Coaching**
- ☐ **Counseling**
- ☐ **Disciplinary Action**
- ☐ **EAP Recommended**

System Design – Note any perceived problems with performance shaping factors that exist within the system and recommendations on how to modify these factors for risk reduction.

Back-up cameras have become more commonplace on the county's apparatus. Our SOP is not specific to this factor and employees may feel like using a spotter is redundant and may not recognize the limitations of back-up cameras. Recommend that SOP be modified and department-wide PowerDMS memo be circulated advising of risks and limitations to back-up cameras.

Supervisor Comments

EMT Brown indicated that he understands the risks associated with backing up without a spotter. He also understands that back-up cameras and are not adequate substitutes for a spotter. EMT Brown is responsive to using a spotter when backing up apparatus. Employee conference form on file.