HQCA
Health Quality Council of Alberta

Just Individual Assessment Guide

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The Health Quality Council of Alberta is a provincial agency that brings together patients, families, and our partners from across healthcare and academia to inspire improvement in patient safety, person-centred care, and health service quality. We assess and study the healthcare system, identify effective practices, and engage with Albertans to gather information about their experiences. Our responsibilities are outlined in the *Health Quality Council of Alberta Act*.

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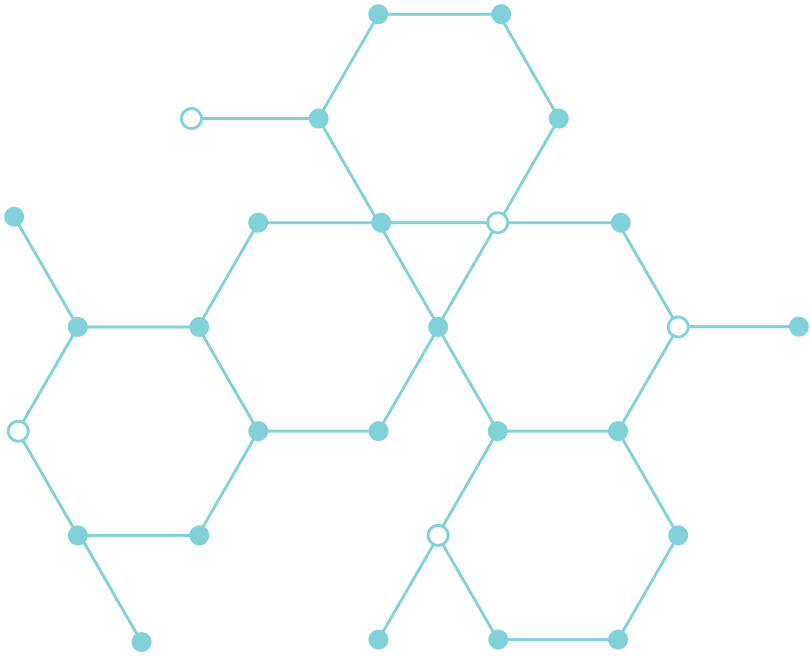

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OVERVIEW

INTRODUCTION

The development of the Just Individual Assessment (JIA) process was influenced by several partner organizations and initiated to support the Health Quality Council of Alberta (HQCA) in its efforts to promote 'just culture.' In addition to these organizations, the work of James Reason, who popularized the concept of just culture as "a key part of an organization's safety culture" has profoundly influenced this work. In his book, *Managing the Risks or Organizational Accidents*,[1] Reason describes a just culture as, "an atmosphere of trust in which people are encouraged, even rewarded, for providing essential safety-related information – but in which they are also clear about where the line must be drawn between acceptable and unacceptable behaviour." In relation to this, Reason's work defines errors as "circumstances in which planned actions fail to achieve the desired outcome."

Reason considered human error to be both universal and inevitable and recognized that people cannot easily avoid actions that they did not intend to commit or did not realize were done in error. Because of this, these situations are on the side of Reason's 'line' that do not warrant discipline. On the other side of the line are 'unacceptable' actions, where there is willful intent to harm. Reason refers to these rare actions as sabotage. More common in healthcare are actions that are much closer to 'the line' such as intentional acts that do not follow standard operating procedures, rules, or an expected standard. The HQCA refers to these as noncompliant actions. Healthcare workers are a part of a complex system, and therefore the HQCA's work in just culture has focused on not judging someone's actions in isolation, but rather to assess them within the context of all other known system factors that could have influenced those actions.

It is important that anyone working in the healthcare system knows that if they are involved in an event where a patient suffered harm, and their actions are called into question, those actions will be assessed in a fair, standardized way, taking into account all other important system factors that influenced the outcome for a patient. The JIA process should be clearly understood and include an appropriate balance of system factors and personal accountabilities. It is essential that organizations keep the wellbeing of the healthcare workers top of mind, recognizing that these assessments, performed in the aftermath of a patient harm event, can be extremely stressful.

What is the JIA?

The JIA provides a fair and standardized approach to evaluate the actions of an individual involved in a patient safety event where a patient was harmed or nearly harmed. For the purposes of this guide, the term 'actions' includes everything the individual did or did not do as well as decisions and choices that they made. The intent is to consider the complex system factors that may have influenced the individual to determine whether restorative measures (e.g., provision of education, addressing underlying health conditions) or disciplinary actions should be considered.

The JIA is an important piece of a health system's just culture which in turn is a cornerstone of a safety culture.

The JIA process provides managers, human resources personnel, regulatory agencies (colleges) and others responsible for assessing the actions of an individual involved in a patient safety incident with the structure and tools to complete the task fairly.

How does the JIA link to Just Culture?

In a just culture, there is support and encouragement for everyone to report hazards, errors, and noncompliant actions with the goal of making the system safer. Reporting will only occur in a workplace where people feel safe to report and know that they will be treated fairly if their actions might have contributed to a patient suffering harm or near harm.

Everyone working in the healthcare system needs to understand what separates tolerable from unacceptable behaviour and to feel confident that errors and some noncompliant actions will not be disciplined.

The JIA outlines an approach that can be used to help define the distinction between tolerable and unacceptable actions. When healthcare organizations and regulatory agencies use a consistent assessment approach, they show a commitment to fairly evaluate the actions of those who are involved in a patient safety event.

What is the JIA not?

The JIA is not intended to manage an individual's performance over time. Nor is it intended to conduct a system level review of an incident where a patient was harmed or nearly harmed. The Systematic Systems Analysis (SSA) methodology[2] can be used separately to conduct patient safety reviews to identify system hazards where improvements could be made.

Depending on the nature of the incident, both SSA and JIA may be required. These processes should be conducted as separate reviews and where possible completed by different people to avoid bias and to ensure protection of information gathered during the SSA if the review has been conducted under quality assurance legislation.

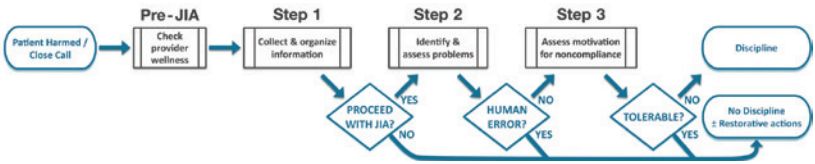
What is the JIA Process?

The JIA process includes one pre-step, three steps, and three decisions. Outcomes for the patient are not considered in the assessment.

The JIA process includes several tools that help complete each step and make decisions. These tools are embedded throughout this guide and are available in the tool directory at the end of this guide.

Being involved in a harm or near harm event can be very stressful, therefore, the JIA starts with a basic question: is the person who is being assessed psychologically fit for the JIA to proceed at this time and do they need any support?

If it is decided to proceed with the JIA, each Step precedes a Decision. The first two decisions are possible 'off-ramps' which, if not taken, results in Step 3 and the last decision, which is related to the concept of discipline. The JIA may suggest a need for restorative actions for the individual – these are actions meant to help them in the future and they should not be considered, or mistaken for, disciplinary action.



THE JUST INDIVIDUAL ASSESSMENT OUTLINE

The Just Individual Assessment (JIA) provides a fair and standardized approach to evaluate the actions (or inactions) of an individual involved in a patient safety event when there are questions or concerns regarding the individual's role in the event.

Pre-JIA: Check provider wellness

Ask questions and take steps to support the individual involved. Proceed with the JIA if wellness allows.

Step 1: Collect and organize information

Information will be collected initially to determine if impairment contributed to the individuals action and if peers would have behaved differently in the same situation. If the JIA proceeds, further information is required to understand the actions of the individual within the context of the event.

Decision 1: Proceed with JIA?

Is impairment thought to have contributed to the patient event? Impairment could be related to a medical condition or substance use.

NO

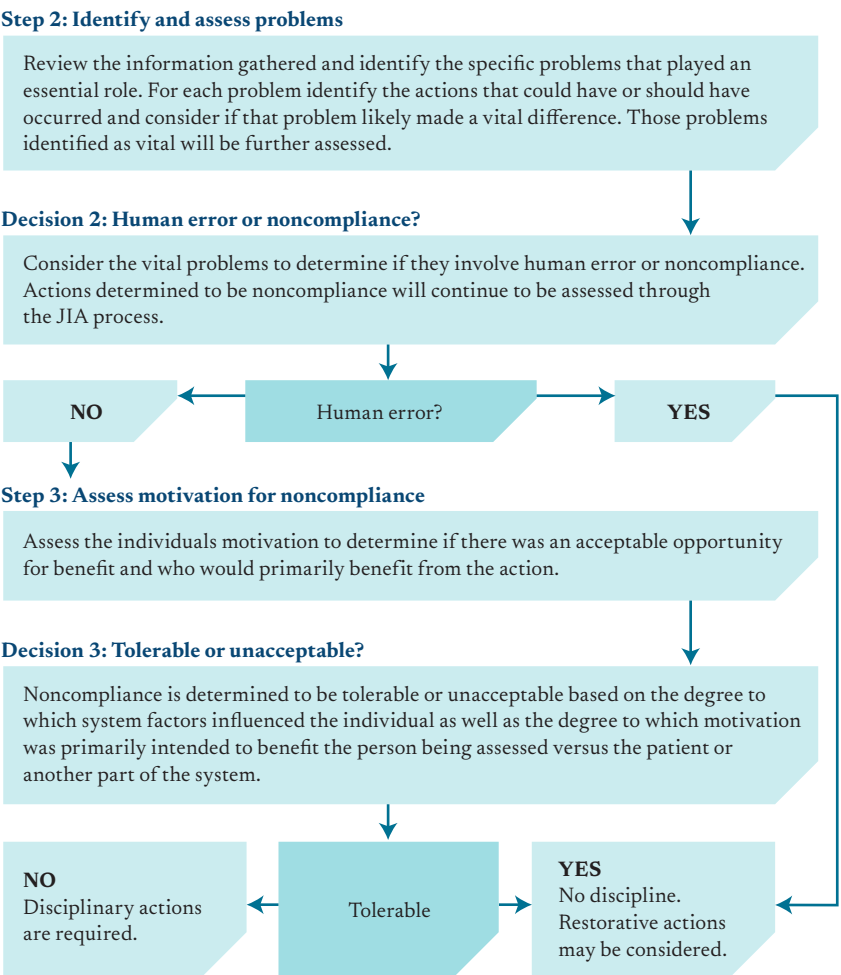
YES → **STOP JIA**
Consult with HR and/or regulatory colleges.

Would peers have done (or not done) the same thing?

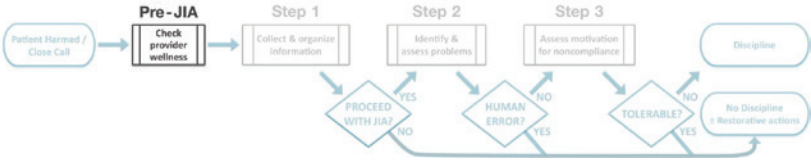
NO

YES → **STOP JIA**
If peers would have done (or not done) the same thing, this suggests a system evaluation is more applicable.

Proceed with JIA → *Proceed to Step 2


Step 2: Identify and assess problems
Review the information gathered and identify the specific problems that played an essential role. For each problem identify the actions that could have or should have occurred and consider if that problem likely made a vital difference. Those problems identified as vital will be further assessed.
Decision 2: Human error or noncompliance?
Consider the vital problems to determine if they involve human error or noncompliance. Actions determined to be noncompliance will continue to be assessed through the JIA process.
NO
Human error?
YES
Step 3: Assess motivation for noncompliance
Assess the individuals motivation to determine if there was an acceptable opportunity for benefit and who would primarily benefit from the action.
Decision 3: Tolerable or unacceptable?
Noncompliance is determined to be tolerable or unacceptable based on the degree to which system factors influenced the individual as well as the degree to which motivation was primarily intended to benefit the person being assessed versus the patient or another part of the system.
NO
Disciplinary actions are required.
Tolerable
YES
No discipline.
Restorative actions may be considered.

PRE-JIA



Before getting started

Those who have been involved in an event where a patient has suffered harm, often experience serious psychological distress. This distress can include guilt, remorse, self-doubts, and a sense of professional incompetence. In addition, those involved can experience physical symptoms such as sleep loss, fatigue, and poor appetite/nausea. A healthy organizational response to serious patient safety incidents recognizes the psychological and physical toll this experience may take on those involved and ensures supports are available for everyone impacted. This sends a message to all involved that their wellbeing is, first and foremost, an important consideration. The response also initiates proactive steps to manage the required support, especially if a formal assessment of an individual's actions is to take place.

Complete the Provider Wellness Check

Use the Provider Wellness Check tool as a guide for questions to ask and steps to take to support someone involved in events that led to patient harm or near harm.

PROVIDER WELLNESS CHECK

Ask Questions

1. Is the individual psychologically and/or physically capable of providing care to patients?
2. Is the individual at risk of self-harm? Does the individual need immediate intervention?
3. How is the individual handling the different aspects of distress?

- Physical, e.g., sleep
- Psychological, e.g., depression and anxiety
- Social, e.g., family and professional relationships

4. Does the individual have:

- Trusted peer supports? It's important to have a trusted professional colleague with whom the care provider can discuss the event.
- Supportive family members or friends? The individual should be encouraged to share aspects of the event with a family member or friend and to describe and discuss the distress they may be feeling.

5. Does the individual have access to professional counselling? This might be available through an employer or a professional association. See the examples below:

- **Employee and Family Assistance Providers (EFAPs):** Alberta Health Services: 1.877.273.3134 www.homeweb.ca
- **Medical staff:** Alberta Medical Association's Physician and Family Support Program (PFSP): 1.877.SOS.4MDS (1.877.767.4637)
- **Pharmacists:** Alberta Pharmacists' Association Wellness Program https://rxa.ca/member-benefits/wellness-program/

6. Professional protective associations may offer advice that can be reassuring to the individual involved.

- **Nurses:** Canadian Nurses Protective Society: 1.800.267.3390 https://www.cnps.ca/
- **Physicians:** Canadian Medical Protective Association (CMPA): 1.800.267.6522 https://www.cmpa-acpm.ca/en/home
- **Pharmacists:** Canadian Pharmacists Benefits Association (CPBA): 1.866.214.2936

Take action

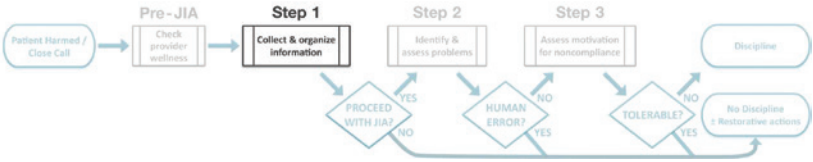
If the assessor has any concerns about the individual's physical or psychological wellbeing, they should take the following steps.

- Encourage the individual to contact their systems of support as outlined above.
- Arrange for them to take some time away from work – this may need to be done in partnership with human resources, if the individual is an employee.
- If there is an immediate concern the individual may be considering self-harm, contact human resources and/or ask the individual for permission to initiate urgent mental health support. There are 24/7 mental health phone numbers (e.g., Mental Health Help Line:1.877.303.2642) or emergency departments/urgent care centres that can be accessed.

Proceed with the Just Individual Assessment only if wellness allows. If the assessment indicates the individual is not coping well, defer the JIA and focus on helping the individual obtain appropriate support.

STEP/DECISION 1

STEP 1 – COLLECT AND ORGANIZE INFORMATION



Actions

1. Review patient chart information
2. Start the Chronology of Events Table
3. Conduct interviews
4. Complete the System Factors Table

Overview

Gathering information about an event is often an iterative process. To start, information is usually gathered from the patient's chart. There may also be some preliminary conversations or interviews with people who were involved in the events leading up to a patient being harmed. It is helpful to look ahead to each of the steps and decision points in the JIA to determine what information is required and to consider how it will be acquired.

First, gather enough information to determine if it's necessary to proceed with a formal Just Individual Assessment (JIA). This decision will consider if impairment may have contributed and if peers would have acted differently. Secondly, information about system factors should be gathered and used to place an individual's actions into proper context and to facilitate the fair evaluation of what the individual did or did not do, should the JIA process continue.

Organize information in a Chronology of Events Table and a System Factors Table.

Review patient chart information

- Chart information useful for the Chronology of Events Table may include:
  - Actions or decisions made by the patient leading up to the events that are being assessed.
  - Timing of when various personnel interacted with the patient and/or the person who is being assessed, and what happened in those interactions.

- Timing and the nature of interactions with the patient and actions taken in preparation for the delivery of care.
- Tests or procedures that were performed – when they were ordered and when they were completed. It may also be important to understand when people became aware of important results.
- Timing of treatment(s) given to the patient and their response.
- Scheduled actions that were intended to be completed but for some reason were not.

The purpose of establishing a chronology is to determine the sequence of events leading to, during, and possibly after the event under analysis. This will help develop an understanding of what, when, and how it occurred. An initial chronology can help answer the question about whether to proceed with a formal JIA and more details can be added if a decision to proceed is made.

The basic format for a chronology is a three-column table.

- **Date/Time:** lists the date and time of the event or the piece of information. When the chronology is first created, a decision needs to be made about when to start the chronology and when to end it.
- **Event/Condition/Information:** describes the event that happened or the relevant piece of information.
- **Source:** gives the source of information if additional information is required or if details of what was collected need to be checked. Sources of information include the patient's medical record, charts, interviews, and other documents, such as laboratory or diagnostic information systems.

Although it is helpful to be able to see the sequence of events based on time, this temporal relationship should not be mistaken for one of cause and effect.

The chronology can be supplemented or updated when undertaking interviews with various individuals. Interviewees should be offered the option to review the facts established in the chronology and can suggest changes and/or additions. Notes that include opinion or speculation should not be shared. Ensure that the source of each piece of information is not shown (column three). This is to ensure the anonymity and privacy of everyone involved in the event and the analysis.

CHRONOLOGY OF EVENTS TABLE: EXAMPLE

DATE/TIME	EVENT/CONDITION/ INFORMATION	SOURCE
2023-11-13 /10:14	RN1 received a phone call from MD1 who requested patient W.N. have his O_2 increased from 6 LPM to 8 LPM and to discontinue O_2 on patient R.P. (was currently on 1 LPM).	Nursing progress note
2023-11-13 /10:14	RN1 received the orders without verifying each patient's identity prior to receiving the order and did not read back each order to confirm accuracy. RN1 was not aware of the organization's policy on telephonic/ verbal orders.	Interview with RN1
2023-11-13 /10:15	RN1 entered a telephone order from MD1 to discontinue O_2 on patient W.N. – then sent a message to RN2 to act on the order.	EMR order log
2023-11-13 / 10:16	RN1 called urgently to room 4-37 to attend to patient C.C. who had fallen in the bathroom.	Nursing progress notes
2023-11-13 / 10:17	RN2 discontinued O_2 on patient W.N.	Nursing progress notes
2023-11-13 / 10:29	RN1 entered a telephone order from MD1 to increase O_2 on patient R.P. to 8 LPM.	Nursing progress notes
2023-11-13 / 10:33	RN3 went to increase O_2 on patent R.P. to 8 LPM but questioned the order so reviewed with RN1 verbally at the main desk.	Interview with RN3
2023-11-13 / 10:33	RN1 called RN2 to inform her the O_2 order on patient W.N. was entered incorrectly and asked for the O_2 to instead be increased to 8 LPM.	Interview with RN1
2023-11-13 / 10:34	RN2 urgently went to see patient W.N. who was found unresponsive, weak pulse (~ 40/min), O_2 saturation not registering, BP not recordable – Code Blue called.	Interview with RN2 and Nursing progress notes

Conduct interviews

Interviews are also an important source of information. Before conducting an interview, start with a clear view of what information is required from each interviewee and review the Interview Guide.

Anyone, including the patient and family members, involved with the events that took place, can be asked about the sequence of events. In some situations, interviewing peers and subject matter experts who were not part of the events can add important information.

Interviewees may be able to provide opinions and perspectives about:

- Which actions were likely to have been the most problematic.
- The range of actions that similar people may or may not have taken in the same situation.
- Where the problems with the actions may have arisen and thus whether they should be considered error(s) or noncompliance.
- System factors and the effect they may have had on the individual's decision-making and actions (see the System Factors Guide).
- Whether the actions were understandable given the situation (system factors) the individual was dealing with at the time.
- The possible motivation for the individual's actions.

INTERVIEW GUIDE

Before conducting any interviews:

- Review the just assessment process steps and questions to determine what information will be required.
- Plan the sequence of interviews: If possible, the patient and family members should be interviewed first as they have insight into the events leading up to the incident.
- If peers or subject matter experts will be interviewed, consider what situational information about the events will be provided to them:
  - The purpose of interviewing people who were not involved in the events is to gather additional information and perspective. This may be influenced by the amount of information they are provided about the events.
  - As a general rule, they should be provided with the same situational information the person who is being assessed had when events were unfolding. For example, how many other patients the person was caring for and the availability of needed personnel or equipment.

Before asking interview questions:

- Explain to the interviewee what the purpose of the interview is, how the information will be used, and how it will remain confidential.
- Start with a clear view of what information is required.
- Be prepared with open-ended, non-leading questions; avoid rhetorical questions.
- If interviewing peers or subject matter experts, explore any biases the interviewee may have about the case and how much they are aware of it. If they are aware of the outcome for the patient, coach them not to consider it in their answers.

During the interview:

Collect information specifically about:

- The events leading up to the patient safety incident:
  - What happened and how the interviewee was involved.
  - When things happened – record this information in the Chronology of Events Table.
  - Show the interviewee the current chronology so they can be asked to provide additional details about events already recorded, and also so they can see what is missing.

TIP: An interviewee may have a different idea of what and when events happened compared to what is currently recorded in the chronology. Therefore, it is advisable that if they are shown the chronology then the third column (source) must not be revealed. If an assessor has more than one version of events, keep all versions in the 'master chronology' and keep them separated by highlighting them with different colors or use different fonts.

- The context of care which will help the assessor to identify system factors:
  - Review the System Factors guide and use it to formulate questions.
  - Record what was learned in the System Factors Table.
- Problems that appeared to have occurred:
  - Review the problem analysis sheet.
    - Be prepared to answer the questions about an action and about the steps in the information processing sequence that preceded the decisions that were made to act or not to act.
    - Understand what could have or should have happened.
    - Which specific problem(s) they considered were the greatest contributors to the patient's outcome or close call.
  - What appeared to be the primary motivation for the individual's actions – did it seem they were done more for the patient's benefit or the individual's benefit?
- If the interviewee is a peer or subject matter expert who is providing insights that will be used to assess actions:
  - Review the Peer Review Guide.
  - Select an appropriate peer for this test.
  - Have available an accurate summary of the chronology of events and the important system factors that could have influenced the actions of the individual under assessment that the individual would have been aware of at the time events took place.

A note about peers and subject matter experts
Peers may be helpful sources of information about standards or rules that govern the types of decisions and actions that were undertaken and may provide perspective about how often most people adhere to them. Subject matter experts (SMEs) may yield additional information, particularly in cases in which the decisions made and the actions undertaken by the individual were not expected. SMEs may also be able to suggest which one or more system factors might have contributed to the event, particularly those that could interfere with workers' abilities to follow standards or rules.

TIP: Consulting the Bias Awareness Guide before conducting interviews helps to become aware of possible biases and steps to minimize these biases.

BIAS AWARENESS GUIDE

Background

Making a fair assessment of an individual's actions requires that an assessor has insight into subconscious biases to which every human is prone. Unchecked, these biases can contribute to unfair assumptions about an individual and the actions they took (or did not take). Four common biases that might influence how an assessor evaluates and makes decisions about an individual's actions are described below. Reviewing this information before conducting interviews may help an assessor avoid asking biased questions.

After completing an assessment, but before making any decisions, an assessor should review these biases. This awareness will help to make decisions that are fair to everyone involved.

Four biases and their proactive and reactive debiasing strategies

1. Hindsight bias:

- **Description**
  - This is the tendency, knowing what ultimately happened, to view how things unfolded in a different light. Hindsight bias leads an assessor, peers and others, including the patient, to believe the individual could have predicted the outcome beforehand and therefore should have made different decisions and taken different actions than they did. Knowing the outcome can profoundly influence the perception of past actions and behaviours and thus minimize a realistic (objective) appraisal of what occurred. Hindsight bias can also lead an assessor to believe the decisions that should have been made and the actions that were taken (or not taken) were much more obvious than they were at the time. This bias can be rewritten as 'easy to see it coming, once it has come.'
- **Debiasing strategies:**
  - **Proactively**, the assessor can try not to learn about the outcome for the patient. In addition, the assessor should not inform any of the interviewees about the patient's outcome.
  - **Reactively**, if the assessor knows what the patient's outcome is, then an awareness of this bias will help to limit its effect. Also, the assessor should purposely think about what information the individual had at the time they were making decisions and undertaking actions, and how quickly events might have been unfolding. In other words, the assessor should try to estimate how much pressure the individual was under to process information, make decisions and take actions quickly, while recognizing the individual did not know what was coming. The assessor should also counsel interviewees to put aside (as much as possible) any knowledge they have of the patient's outcome. The assessor may also want to consider outcomes that didn't occur but could have as a reminder that the outcome was not foreseen or inevitable.

2. Illusion of free will:

- **Description**
  - This is the belief that each one of us can choose to be perfect. In addition, when something untoward happens, the individual who was involved, at some level, made a conscious choice to perform below that standard of perfection.
- **Debiasing strategies**
  - **Proactively**, the assessor, through awareness of this bias, should temper their idea of what an individual 'should have done' and endeavour to think about what most people 'would have done' in a similar situation.
  - **Reactively**, the assessor can ask themselves if they have been influenced by this bias and revisit some of their conclusions, up to and including the analysis of information processing and actions.

3. Fundamental attribution error:

- **Description**
  - This error is made when the assessor links an act of omission or commission to some aspect of the individual's personality or even a character defect. An example of this bias: 'they forgot because they are lazy' or 'they just don't care.'
- **Debiasing strategies**
  - **Proactively**, an assessor through awareness of this bias, would check if they have any preconceived impressions of the individual's physical, psychological or personality traits (positive or negative) and be aware of any emotional reactions they have to any of these traits. When making judgments at any phase of the assessment, the assessor should reflect on any emotions they have about the event and/or the individual. In addition, if the assessor disagreed with the opinions of peers, then it is possible that the resulting analysis could be biased. The assessor should therefore pay extra attention to the possibility their thinking has been influenced by this bias.
  - **Reactively**, the assessor should ask themselves if they have been influenced by this bias and revisit some of or all of their conclusions.

4. Symmetry bias:

- **Description**
  - This bias relates to the common tendency to link the seriousness or the horror of the outcome with the seriousness of the actions. This reaction can be restated as 'the patient suffered severe harm in part because the individual forgot to do one task – and therefore this omission was a serious error, or even an egregious error.' This concept should be avoided, as should using adjectives such as trivial, serious or egregious to describe errors.

- **Debiasing strategies**
  - **Proactively**, like dealing with the Fundamental Attribution Error, the assessor should note any emotions evoked when they think of the patient's outcome, if they are aware of it. They should then check to see if this emotion influences any judgments as they make them.
  - **Reactively**, the assessor can ask themselves if they have been influenced by this bias and revisit some of or all their conclusions.

Complete the System Factors Table

As information from the patient's chart and interviews is collected and organized into a chronology of events table applicable information should be entered into a System Factors Table for use in later steps. Examples of information that might be collected could include organizational policies, professional guidelines, and regulatory standards. It may also include product descriptions, photographs of the work environment and procedure manuals. The type of information that could be relevant to include can be found in the System Factors Guide.

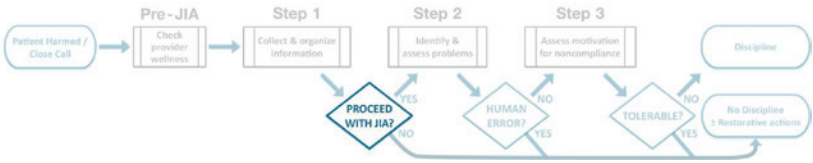
SYSTEM FACTORS GUIDE

System Level	System Factors
Patient	Possible relevant factors: ▪ Patient identification ▪ Personal characteristics ▪ Important conditions the patient had ▪ medications the patient was taking (prescription, over-the-counter, herbal) ▪ Important decisions and actions taken by the patient
Personnel ▪ individual being assessed ▪ other personnel ▪ team, if there was one	Possible relevant factors: ▪ Physical characteristics and professional characteristics ▪ Training or experience ▪ Workload, rostering/scheduling/call ▪ Tasks the individual was required to undertake, and the requirements for them ▪ Personal physical and training requirements to complete the task ▪ Generally accepted standards of practice and whether they were met ▪ Possible impairment due to a medical condition and/or recent use of alcohol or drugs

SYSTEM FACTORS GUIDE – CONTINUED

System Level	System Factors
Personnel ▪ individual being assessed ▪ other personnel ▪ team, if there was one	Make notes about the team. In addition to the above, other relevant factors may be: ▪ Team formation – experience and training of team members ▪ Team leadership – management, direction, supervision
Environment/ Equipment	Possible relevant factors: **Environment** ▪ Design/construction of the environment(s) where activities related to patient care took place (e.g. space/physical lay-out, lighting, ventilation, temperature, noise, busyness) ▪ Planned/scheduled housekeeping or maintenance of the environment ▪ Purpose/planned use of the environment ▪ The effect the environment had on how care was delivered **Equipment** ▪ The design, manufacture or maintenance of the equipment ▪ Planned introduction of the equipment (e.g. with orientation/training or standard replacement) ▪ Planned use of the equipment ▪ Planned supply of equipment ▪ Maintenance of the equipment
Organization	Possible relevant factors: ▪ Policies, procedures (standards) and manuals ▫ Available/understandable/usable ▫ Relevant/accurate/up to date ▫ Any conflict with other organizational policies ▪ Communication channels – sharing information ▫ Available/used ▪ Funding/budget goals and priorities
Regulatory Agencies	Possible relevant factors: ▪ Policies, procedures (standards) and manuals ▫ Available/understandable/usable ▫ Relevant/accurate/up to date ▫ Any conflict with other regulatory policies or with organizational policies ▪ Communication channels – sharing information ▫ Available/used ▪ Funding/budget goals and priorities

DECISION 1 – PROCEED WITH JIA



Decision: Should the JIA proceed?

- Determine if impairment may have contributed:
  - If impairment may have contributed – **stop the JIA**, consider a different process, consult with HR and/or regulatory agencies.
- Determine if peers would have behaved differently:
  - If peers would not have behaved differently – **stop the JIA**, consider conducting a systematic systems review.
  - If peers would have behaved differently – **continue with the JIA.**

Overview

Before proceeding with the next steps of the JIA, it first needs to be determined if it is the correct process to use and if a complete assessment is necessary. This decision is based on whether impairment may have contributed and whether it is probable that peers would have behaved differently.

Determine if impairment may have contributed

Determine if there is any chance the decisions and actions of the individual who is being assessed were influenced by impairment. Impairment may be the result of:

- A medical condition or the treatment of a medical condition including the use of prescribed drugs, or
- The use of alcohol, cannabis products, or illegal drugs/prohibited substances.

If there is a chance the individual was working while impaired, inquiries should be made of the people involved in the events leading up to a patient being harmed. This could include the patient or family members if they were present at the time.

If there is good reason to believe that such impairment of the individual played a role in the events that harmed or nearly harmed a patient, stop the JIA. Although every organization will have its own protocols, such a situation warrants consultation with a human resources specialist and, where applicable, may also include the individual's regulatory college.

If impairment is not indicated to have played a role, continue with the JIA, and determine if peers would have behaved differently.

Determine if peers would have behaved differently

When it is not clear that the person who is being considered for a JIA did anything incorrect or outside the realm of what most people would do in similar circumstances, it is helpful to use a substitution test. This test provides an opinion about the decisions and actions of the individual being assessed. This test has been used in aviation and industry, and more recently in healthcare. To conduct a substitution test the following question is asked:

"In the light of what I know about how events unfolded in real time, is it probable that peers would have behaved any differently?"

If it is difficult to make this comparison, because of lack of knowledge or expertise, this question may be asked of peers. If this is done the Peer Review Guide includes information to assist with this process.

If peers would not have behaved differently – stop the JIA
If the answer to the question is 'No, peers would not have behaved any differently,' then no further assessment of the individual is needed. Consider conducting a Systematic Systems Analysis.

If peers would have behaved differently – continue with the JIA
If the answer to the question is 'Yes, peers would have behaved differently', or 'I am not sure' the JIA assessment proceeds; continue to Step 2.

PEER REVIEW GUIDE

A peer of the individual who is being assessed may be asked for an opinion about the actions of that individual. It is recommended that at least two and preferably more peers are involved so an assessor understands if there is a range of opinions about the tasks that are being assessed and the decisions made and actions undertaken. The peers' opinion would include the type of decisions they would have made, and what actions they would or would not have carried out, if faced with the same situation the individual was dealing with during the event leading up to a patient being harmed or nearly harmed. Peers may also be helpful sources of information about standards or rules that govern the types of decision and actions that were undertaken and may provide perspective about how often most people adhere to them. Peers' explanations may help an assessor understand system factors that interfere with workers' ability to follow standards or rules.

A peer review may be used early on to determine whether to proceed with the JIA (Decision 1), or later to assess noncompliance (Step 3) to interpret a complex situation where there were multiple system factors that importantly affected an individual's decision and actions.

For the peer review to be fair, the following approach is recommended:

1. Involve peers who have similar training and experience as the individual being assessed. It is recommended that at least two or preferably more peers are involved to understand if there is a range of opinions about the tasks being assessed.
2. Select peers who do not have obvious biases. For example, this could be a strong personal connection (positive or negative) with the patient or the individual under assessment.
3. Select peers who do not know about the case. If this is not possible or practical then the peer should be coached to not consider the patient's outcome in their responses.
4. Provide peers with the same information (no more and no less) that the individual had at the time they were making decisions and taking or not taking actions. Peers should also be given the context of the situation including the known system factors that were in effect at the time. They should not be told what decisions were made or action(s) were taken/not taken by the individual.
5. Ask peers individually:
    a. What is normally involved in completing the task(s) that are being assessed?
    b. How are these tasks normally completed?
    c. What is the range of acceptable actions to complete the task(s) in question?
    d. How are things usually done in this workplace?
    e. What actions would they have taken in the situation and under the same circumstances with which the individual was faced?
    f. What do they think of the decisions and actions taken by the individual being assessed?

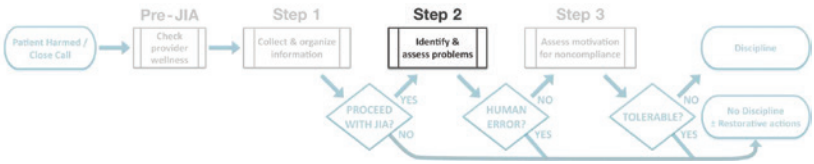
6. Questions should be open-ended and not leading. It should not be obvious from the way questions are asked that there is an expected answer.

7. Peers should be coached to consider that there is no single 'correct' answer.

If peers do not endorse or support in any way, the decisions made (or not) and/or actions that an individual took then the assessor may be dealing with actions that were unacceptable. If this is so, then an assessor may wish to explore further i.e. double-check, with the peers about their opinions to ensure they were properly understood.

STEP/DECISION 2

STEP 2 – IDENTIFY AND ASSESS PROBLEMS



Actions

1. Review the Chronology of Events Table
2. Complete a Problems Identification Table

Overview

The analysis of the individual's actions that are felt to be a problem will help to understand their thinking. The information that was gathered in the Chronology of Events Table will help with the analysis.

Review the Chronology of Events Table

Start by reviewing the Chronology of Events Table to identify and highlight the specific actions that seemed problematic, and that may have most contributed to the patient's outcome or close call. Those are the issues that will be analyzed in the Problem Identification Table.

Complete a Problems Identification Table

As there may be several problematic actions leading to the overall event, it is important to determine the specific actions that played an essential role. It is ideal to list three or fewer problems in the problem identification table, and in some cases there's only one. Depending on the situation, it may be easy to identify and select these specific problems or, in some cases, assistance from peers and subject matter experts may be required.

USING THE PROBLEMS IDENTIFICATION TABLE

For each event, enter the following information:

- Individual being assessed: identify who is being assessed.
- Event description: write a brief (one or two sentence) description of the overall event.
- Specify problems: list the problems that were highlighted on the Chronology Events Table. The date and time of each problem should also be included.

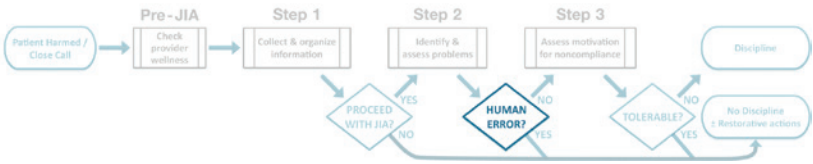
- Suggested options: identify actions that could or should have occurred in this situation.
- Vital difference: answer 'Probably' or 'Probably not' as to whether the difference between what did occur and what should have occurred what should have occurred was vital (directly led to) to the patient's outcome. If the answer is 'Probably', then the problem will undergo further assessment in the next step, to determine if it was more likely a result of human error or noncompliance.

PROBLEMS IDENTIFICATION TABLE: EXAMPLE

Event description: A verbal order for oxygen to be discontinued on a patient was entered into the wrong patient's chart.		
Specify problems (what was done or not done) [Include date and time]	**Suggested options** (what could or should have been done or not done)	**Vital difference?** (Probably/ Probably not)
The charge nurse (RN1) accepted two telephonic orders from MD1. [2023-11-13; 10:14]	(RN1) could have chosen to ask MD1 to enter his orders for changing O_2 flow rates on patients W.N. and R.P.	**Probably not**
RN1 entered one verbal order on the wrong patient (to discontinue O_2). [2023-11-13; 10:15]	(RN1) could have documented and read back each order as it was received.	**Probably**
RN1 sent a message to the bedside nurse (RN2) to discontinue O_2 on patient W.N. but did not speak directly to the nurse. [2023-11-13; 10:15]	(RN1) could have spoken directly to RN2; this may have resulted in a conversation about the appropriateness of stopping oxygen on patient W.N.	**Probably**
RN1 did not verify the identity of each patient using two patient identifiers when receiving the orders. [2023-11-13; 10:29]	(RN1) could have confirmed patient identity using two identifiers prior to accepting each order.	**Probably not**

For each problem where there was probably a vital difference between what was done (or not done) and what could have been done (or not done), further assessment to characterize the actions as error or noncompliance will need to be completed.

DECISION 2 – IS IT HUMAN ERROR OR NONCOMPLIANCE?



Decision: Were the problems human error or noncompliance?

- Determine if the actions are consistent with human error – if actions are believed to be human error, **stop** the JIA, discipline is not warranted, consider restorative actions as appropriate.
- Determine if the actions are consistent with noncompliance – if it is believed to be noncompliance then **proceed** with Step 3 of the JIA.

Overview

Actions assessed by the JIA are classified as either human error or noncompliance. Actions determined to be human error will not be assessed further; actions determined to be noncompliance will continue to be assessed through the JIA process.

Determining if a human error occurred requires a careful review of the problems identified in the Problems Identification Table from Step 2. Each specific problem where there is an answer of 'probably' in the table's vital difference column requires the problem to be characterized as human error or noncompliance.

If all problems are characterized as human error, then there is no indication for discipline and the JIA stops. Restorative actions may still need to be considered in the spirit of learning and improving.

If one or more problems are characterized as noncompliance, then proceed to Step 3 to assess the motivation for noncompliance.

Determine if the actions are consistent with human error

Various considerations will help determine if the specific problems that were directly related to the patient's outcome or close call are best characterized as human error. The following definition and considerations are provided to help with this determination.

- Human Error: "The failure of a planned sequence of mental or physical activities, to achieve its intended outcome, when these failures cannot be attributed to chance."[3] Human error includes actions or decisions that were unintended or not known to be incorrect including:
  - Slips – doing something unintentionally
  - Lapses – forgetting to do something
  - Mistakes – decisions or actions were intended, but were not known to be incorrect

If all problems with the actions are characterized as human error, then there is no indication for discipline and the JIA stops. There may be a role for restorative actions. Restorative actions are non-punitive and designed to preserve and/or enhance an individual's future performance.

Determine if the actions are consistent with noncompliance

- Noncompliance: Deliberately deviating from an accepted protocol or standard of care. For an action to be considered noncompliant, the individual must have:
  - Known about the protocol or standard of care
  - Had the opportunity to follow the protocol or standard of care
  - Intentionally chosen to perform (or not perform) the actions knowing that it was a deviation from an accepted protocol or standard of care.

If these criteria are met, the problem(s) with the actions are consistent with noncompliance and the JIA continues. If these criteria are not met, consider conducting a systems evaluation.

<table>
<tr><td colspan="2">Example: I didn't bring lunch to work today</td></tr>
<tr><th>Human Error</th><th>Noncompliance</th></tr>
<tr><td>Slip – grabbed the wrong bag out of the fridge</td><td rowspan="3">I knew that I was supposed to bring dessert for the staff potluck, I know how to make dessert and had the ingredients, but I chose not to bring anything.</td></tr>
<tr><td>Lapse – forgot to grab my lunch out of the fridge</td></tr>
<tr><td>Mistake – thought lunch was provided in a team meeting today</td></tr>
</table>

Restorative actions

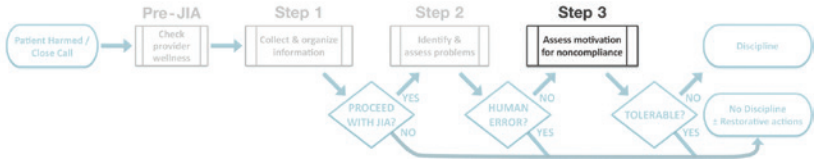
Restorative actions are non-punitive and designed to protect and/or enhance an individual's future performance. This type of response is usually chosen when the individual's decisions and actions are thought to be errors or certain types of noncompliance.

EXAMPLES OF RESTORATIVE ACTIONS INCLUDE:

- Treatment for a health condition (physical or psychological)
- Further physical, psychological or cognitive assessment
- Education or training
- Coaching
- Modification of the individual's job or practice in a temporary or permanent way that would involve changing:
  - The scope of work
  - The amount of work
  - The assigned responsibilities
  - The timing of work (e.g., number of consecutive hours, types of shifts)
  - The location of work

STEP/DECISION 3

STEP 3 – ASSESS MOTIVATION FOR NONCOMPLIANCE



Actions

1. Review the System Factors Table
2. Answer the Motivation for Noncompliance Questions

Overview

At this stage in the Just Individual Assessment an individual's actions have been characterized as noncompliance. Those actions now need to be assessed within the context of the system factors that likely had an effect, along with the motivation of the individual.

Review the System Factors Table

The System Factors Table was completed in Step 1 based on information from chart reviews and interviews. This information should be considered when assessing the motivation of the individual.

Answer the Motivation for Noncompliance Questions

Understanding what motivated an individual to take, or not take, the actions can be challenging. The Motivation for Noncompliance Questions are designed to help gather information about an individual's motivation. This opinion will be shaped by what was learned from many sources of information but in particular the interviews conducted. Directly asking the individual being assessed about their motivation may or may not provide useful insight.

MOTIVATION FOR NONCOMPLIANCE QUESTIONS

Based on the information included in the System Factors Table, which includes information from chart reviews and interviews:

Part I – Was there an acceptable opportunity for benefit?
Are there good reasons to believe the actions taken by the individual had a reasonable chance of benefiting the patient(s)?

☐ **Yes:** Motivation was for benefit rather than harm and the chance of patient benefit was reasonable.

Continue to Part II

☐ **No:** Motivation was either to harm the patient or to accept an inappropriately high chance of harming a patient. In either case, the actions were unacceptable. In this uncommon scenario, the assessor should consider discipline. Involvement of human resources and/or the appropriate regulatory college is recommended. The JIA stops.

Part II – Identify the primary intended beneficiary
Who or what was more likely to obtain the majority of the benefit from the individual's actions?
(Choose one response)

☐ **Patient**

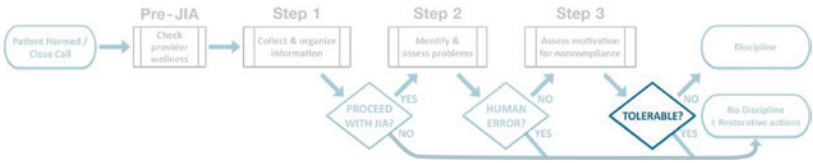
☐ **The individual** (e.g., financial, saving time, reputation)

☐ **Another part of the system** (e.g., helping another patient, helping a colleague, saving resources)

NOTE: Other parts of the system mean not the patient and not the individual who is being assessed. This could be other patients or co-workers (e.g., not keeping someone waiting), environment/equipment, or the organization (e.g., saving the organization money).

The response will be used with Decision 3 – Tolerable?

DECISION 3 – IS THE NONCOMPLIANCE TOLERABLE?



Decision: Were the actions tolerable or unacceptable?

- If tolerable, consider restorative actions.
- If unacceptable, disciplinary actions are indicated.

Overview

An individual's actions were previously characterized as noncompliance and are now assessed to determine if it was tolerable or unacceptable. If tolerable, there should be no discipline; however, there may be a role for restorative actions. If unacceptable, then disciplinary actions are indicated.

Complete the Noncompliance Assessment Matrix

Use the answers from the Motivation for Noncompliance Questions and the information from the System Factor Table to plot the motivation for noncompliance and the degree of system factors influence on the Noncompliance Assessment Matrix. This will help to identify if the individual's actions were tolerable or unacceptable. A template for the Noncompliance Assessment Matrix can be found in the tool directory at the end of this guide.

- **Motivation for Noncompliance:** use the responses in Part II of the Motivation for Noncompliance Questions to plot the degree to which motivation was primarily intended to benefit the person being assessed versus primarily intended to benefit the patient or another part of the system.
- **System Factors Influence:** this input is a judgment based on a review of the completed System Factors Table considering the degree to which system factors influenced the actions of an individual. It is not based on the number of factors that were uncovered as part of that analysis. Instead, it is based on how much it is believed the factors played a role in influencing the individual.

In some situations, the opinion of one or more peers or subject matter experts, used in conjunction with the System Factors Table, can help determine how much influence system factors likely had. The Peer Review Guide can help to ensure that a fair and valuable opinion is considered.

THE FOLLOWING QUESTIONS MAY HELP DETERMINE HOW MUCH INFLUENCE SYSTEM FACTORS HAD:

1. Peer opinions (if obtained):
    a. Did peers describe any differences between how the decisions and actions under evaluation are supposed to be done compared to how they are done in practice?
    b. Did peers highlight any workarounds that are commonly used by people to efficiently complete the tasks under evaluation?
    c. Did peers believe the decisions made to take or not to take an action or series of actions were acceptable/understandable given the situation?
2. What were the major system factors that influenced an individual's actions?
3. How much effect did these system factors have on an individual's decisions and actions?

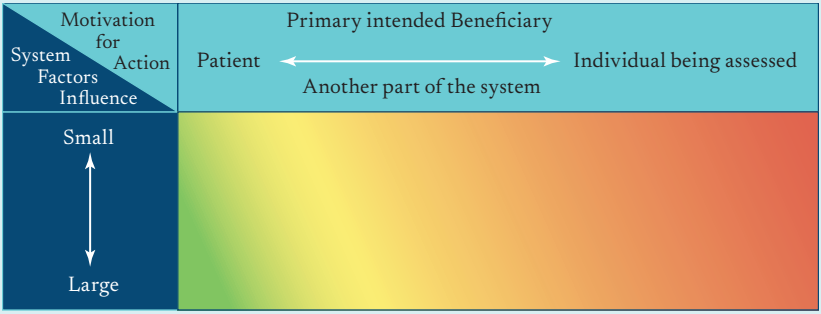
Check for biases

Before finalizing a decision about whether actions were unacceptable, check any possible bias that could have influenced the decision-making. Consult the Bias Awareness Guide. If one or more biases may have impacted judgements with the noncompliance matrix, go back and review the decision about how the individual's actions were classified.

DETERMINE IF THE ACTIONS WERE TOLERABLE OR UNACCEPTABLE

Use the colour legend, the Noncompliance Assessment Matrix, to determine if the individual's actions were tolerable or unacceptable. If they were tolerable, there should be no discipline; however, there may be a role for restorative actions. If they were unacceptable (i.e., those that fall within the red and possibly the dark orange zone), then disciplinary actions are likely needed. In most cases, unacceptable actions are those where system factors did not influence decision-making about actions taken or not taken, and where the actions were primarily intended to benefit the individual being assessed.

Noncompliance Assessment Matrix



*other system component: other personnel, environment/equipment, organization

COLOUR LEGEND

Green = **Tolerable** – discipline should not be considered

Yellow = **Likely tolerable** – discipline should probably not be considered

Orange = **Potentially unacceptable** – discipline may need to be considered depending on other information and its interpretation

Red = **Unacceptable** – discipline should very likely be considered

Closing thoughts

The JIA is an important piece of a health system's just culture which in turn is a cornerstone of a safety culture. The JIA process provides managers, human resources personnel, and regulators who are involved in assessing the decisions and actions of an individual involved in a patient safety event with a framework and tools to complete the task fairly. By applying this process consistently, an organization is demonstrating their commitment to a just culture. When staff are supported when things go wrong and trust that their actions will be assessed fairly, they in turn will be more likely to raise concerns about patient safety and report hazards and errors. This information can then be used to learn and make changes to the system to improve patient safety.

REFERENCES

REFERENCES

1. Reason J. *Managing the Risks of Organizational Accidents*. Aldershot: Ashgate Publisher; 1997.
2. Steinke C, Davies JM. Systematic Systems Analysis: A Practical Approach to Patient Safety Reviews. Calgary: Health Quality Council of Alberta; 2022.
3. Reason J. *Human Error*. Cambridge: Cambridge University Press, 1990.

REFERENCES

TOOLS DIRECTORY

TOOLS DIRECTORY

More information and additional resources are available on our just culture website: https://justculture.hqca.ca

Provider Wellness Check

ASK QUESTIONS

1. Is the individual psychologically and/or physically capable of providing care to patients?
2. Is the individual at risk of self-harm? Does the individual need immediate intervention?
3. How is the individual handling the different aspects of distress?
   - Physical, e.g., sleep
   - Psychological, e.g., depression and anxiety
   - Social, e.g., family and professional relationships
4. Does the individual have:
   - Trusted peer supports? It's important to have a trusted professional colleague that the care provider can discuss the event.
   - Supportive family members? The individual should be encouraged to share at least some of the events with a family member and to describe and discuss the distress they may be feeling.
5. Does the individual have access to professional counselling if it is required? This might be available through an employer or a professional association. See the examples below:
   - **Employee and Family Assistance Providers (EFAPs):** Alberta Health Services: 1.877.273.3134 www.homeweb.ca
   - **Medical staff:** Alberta Medical Association's Physician and Family Support Program (PFSP): 1.877.SOS.4MDS (1.877.767.4637)
   - **Pharmacists:** Alberta Pharmacists' Association Wellness Program https://rxa.ca/member-benefits/wellness-program/

6. Professional protective associations may offer advice that can be reassuring to the individual involved.

- **Nurses:** Canadian Nurses Protective Society: 1.800.267.3390 https://www.cnps.ca/
- **Physicians:** Canadian Medical Protective Association (CMPA): 1.800.267.6522 https://www.cmpa-acpm.ca/en/home
- **Pharmacists:** Canadian Pharmacists Benefits Association (CPBA) 1.866.214.2936

TAKE ACTION

If the assessor has any concerns about the individual's physical or psychological wellbeing they should take the following steps.

- Encourage the individual to contact their systems of support as outlined above.
- Arrange for them to take some time away from work – this may need to be done in partnership with human resources if the individual is an employee.
- If there is an immediate concern the individual may be considering self-harm, contact human resources and/or ask the individual for permission to initiate urgent mental health support. There are 24/7 mental health phone numbers (e.g., Mental Health Help Line:1-877-303-2642) or emergency departments/urgent care centres that can be accessed.

Proceed with the Just Individual Assessment only if wellness allows. If the assessment indicates the individual is not coping well, defer the JIA and focus on helping the individual obtain appropriate support

Bias Awareness Guide

BACKGROUND

Making a fair assessment of an individual's actions requires that an assessor has insight into subconscious biases to which every human is prone. Unchecked, these biases can contribute to unfair assumptions about an individual and the actions they took (or did not take). Four common biases that might influence how an assessor evaluates and makes decisions about an individual's action or inaction are described below. Reviewing this information before conducting interviews may help an assessor avoid asking biased questions.

After completing an assessment but before making any decisions, an assessor should review these biases. This awareness will help to make decisions that are fair to everyone involved.

Four biases and their proactive and reactive debiasing strategies

1. Hindsight bias:

- **Description**
  - This is the tendency, knowing what ultimately happened, to view how things unfolded in a different light. Hindsight bias leads an assessor, peers, and others, including the patient, to believe the individual could have predicted the outcome beforehand and therefore should have made different decisions and taken different actions than they did. Knowing the outcome can profoundly influence the perception of past actions and behaviours and thus minimize a realistic (objective) appraisal of what occurred. Hindsight bias can also lead an assessor to believe the decisions that should have been made and the actions that were taken (or not taken) were much more obvious than they were at the time. This bias can be rewritten as 'easy to see it coming, once it has come.'
- **Debiasing strategies**
  - **Proactively**, the assessor can try not to learn about the outcome for the patient. In addition, the assessor should not inform any of the interviewees about the patient's outcome.
  - **Reactively**, if the assessor knows what the patient's outcome is, then an awareness of this bias will help to limit its effect. Also, the assessor should purposely think about what information the individual had at the time they were making decisions and undertaking actions, and how quickly events might have been unfolding. In other words, the assessor should try to estimate how much pressure the individual was under to process information, make decisions and take actions quickly, while recognizing the individual did not know what was coming. The assessor should also counsel interviewees to put aside (as much as possible) any knowledge they have of the patient's outcome. The assessor may also want to consider outcomes that didn't occur but could have as a reminder that the outcome was not foreseen or inevitable.

2. Illusion of free will:

- **Description**
  - This is the belief that each one of us can choose to be perfect. In addition, when something untoward happens, the individual who was involved, at some level, made a conscious choice to perform below that standard of perfection.
- **Debiasing strategies**
  - **Proactively**, the assessor, through awareness of this bias, should temper their idea of what an individual 'should have done' and endeavour to think about what most people 'would have done' in a similar situation.
  - **Reactively**, the assessor can ask themselves if they have been influenced by this bias and revisit some of their conclusions, up to and including the analysis of information processing and actions.

3. Fundamental attribution error:

- **Description**
  - This error is made when the assessor links an act of omission or commission to some aspect of the individual's personality or even a character defect. An example of this bias: 'they forgot because they are lazy' or 'they just don't care.'
- **Debiasing strategies**
  - **Proactively**, an assessor through awareness of this bias, would check if they have any preconceived impressions of the individual's physical, psychological, or personality traits (positive or negative) and be aware of any emotional reactions they have to any of these traits. When making judgments at any phase of the assessment, the assessor should reflect on any emotions they could be feeling about the event and/or the individual. In addition, if the assessor disagreed with the opinions of peers, then it is possible that the resulting analysis could be biased. The assessor should therefore pay extra attention to the possibility their thinking has been influenced by this bias.
  - **Reactively**, the assessor should ask themselves if they have been influenced by this bias and revisit some of, or all of, their conclusions.

4. Symmetry bias:

- **Description**
  - This bias relates to the common tendency to link the seriousness or the horror of the outcome with the seriousness of the actions. This reaction can be restated as 'the patient suffered severe harm in part because the individual forgot to do one task – and therefore this omission was a serious error, or even an egregious error.' This concept should be avoided, as should using adjectives such as trivial, serious, or egregious to describe errors.
- **Debiasing strategies**
  - **Proactively**, like dealing with the Fundamental Attribution Error, the assessor should note any emotions evoked when they think of the patient's outcome, if they are aware of it. They should then check to see if this emotion influences any judgments as they make them.
  - **Reactively**, the assessor can ask themselves if they have been influenced by this bias and revisit some of, or all of, their conclusions.

CHRONOLOGY OF EVENTS TABLE

Date / Time (yyyy-mm-dd/hr:min)	Event/Condition/Information	Source
2020-01-01 / 00:00		

Interview Guide

BEFORE CONDUCTING ANY INTERVIEWS:

- Review the just assessment process steps and questions to determine what information will be required.
- Plan the sequence of interviews: If possible, the patient and family members should be interviewed first as they have insight into the events leading up to the events.
- If peers or subject matter experts will be interviewed, consider what situational information about the events will be provided to them.
  - The purpose of interviewing people who were not involved in the events is to gather additional information and perspective. This may be influenced by the amount of information they are provided about the events.
  - As a general rule, they should be provided with the same situational information the person who is being assessed had when events were unfolding. For example, how many other patients the person was caring for and the availability of needed personnel or equipment.

BEFORE ASKING INTERVIEW QUESTIONS:

- Explain to the interviewee what the purpose of the interview is, how the information will be used, and how it will remain confidential.
- Start with a clear view of what information is required.
- Be prepared with open-ended, nonleading questions; avoid rhetorical questions.
- If interviewing peers or subject matter experts, explore any biases the interviewee may have about the case and how much they are aware of it. If they are aware of the outcome for the patient, coach them not to consider it in their answers.

DURING THE INTERVIEW:

Collect information specifically about:

- The events leading up to the patient safety incident.
  - What happened and how the interviewee was involved.
  - When things happened – record this information in the Chronology of Events Table.
  - Show the interviewee the current chronology so they can be asked to provide additional details about events already recorded, and also so they can see what is missing.

TIP: An interviewee may have a different idea of what and when events happened compared to what is currently recorded in the chronology. Therefore, it is advisable that if they are shown the chronology then the third column (source) must not be revealed. If an assessor has more than one version of events, keep all versions in the 'master chronology' and keep them separated by highlighting them with different colors or use different fonts.

- The context of care, which will help the assessor to identify system factors.
  - Review the System Factors Guide and use it to formulate questions.
  - Record what was learned in the System Factors Table.
- Problems that appeared to have occurred.
  - Review the problem analysis sheet.
    - Be prepared to answer the questions about an action and about the steps in the information processing sequence that preceded the decisions that were made to act or not to act
    - Understand what could have or should have happened
    - Which specific problem(s) they considered were the greatest contributors to the patient's outcome or close call.
  - What appeared to be the primary motivation for the individual's actions – did it seem they were done more for the patient's benefit or the individual's benefit?
- If the interviewee is a peer or subject matter expert who is providing insights that will be used to assess actions
  - Review the Peer Review Guide.
  - Select an appropriate peer for this test.
  - Have available an accurate summary of the chronology of events and the important system factors that could have influenced the actions of the individual under assessment that the individual would have been aware of at the time events took place.

A NOTE ABOUT PEERS AND SUBJECT MATTER EXPERTS

Peers may be helpful sources of information about standards or rules that govern the types of decisions and actions that were undertaken and may provide perspective about how often most people adhere to them. Subject matter experts (SMEs) may yield additional information, particularly in cases where the decisions made and the actions undertaken by the individual were not expected. SMEs may also be able to suggest which one or more system factors might have contributed to the event, particularly those that could interfere with workers' abilities to follow standards or rules.

TIP: Consulting the Bias Awareness Guide before conducting interviews helps to become aware of possible biases and steps to minimize these biases.

Peer Review Guide

A peer of the individual who is being assessed may be asked for an opinion about the actions of that individual. It is recommended that at least two, and preferably more, peers are involved so an assessor understands if there is a range of opinions about the tasks that are being assessed and the decisions made and actions undertaken. The peers' opinion would include the type of decisions they would have made, and what actions they would have or not have carried out, if faced with the same situation the individual was dealing with during the event leading up to a patient being harmed or nearly harmed. Peers may also be helpful sources of information about standards or rules that govern the types of decision and actions that were undertaken and may provide perspective about how often most people adhere to them. Peers' explanations may help an assessor understand system factors that interfere with workers' ability to follow standards or rules.

A peer review may be used early on to determine whether to proceed with the JIA process (Decision 1), or later to assess noncompliance (Step 3) to interpret a complex situation where there were multiple system factors that importantly affected an individual's decision and actions.

FOR THE PEER REVIEW TO BE FAIR, THE FOLLOWING APPROACH IS RECOMMENDED:

1. Involve peers who have similar training and experience as the individual being assessed. It is recommended that at least two or preferably more peers are involved to understand if there is a range of opinions about the tasks being assessed.
2. Select peers who do not have obvious biases. For example, this could be a strong personal connection (positive or negative) with the patient or the individual under assessment.
3. Select peers who do not know about the case. If this is not possible or practical then the peer should be coached to not consider the patient's outcome in their responses.
4. Provide peers with the same information (no more and no less) that the individual had at the time they were making decisions and taking or not taking actions. Peers should also be given the context of the situation including the known system factors that were in effect at the time. They should not be told what decisions were made or actions were taken/not taken by the individual.

5. Ask peers:
    a. What is normally involved in completing the tasks that are being assessed?
    b. How are these tasks normally completed?
    c. What is the range of acceptable actions to complete the tasks in question?
    d. How are things usually done in this workplace?
    e. What actions would they have taken in the situation and under the same circumstances with which the individual was faced?
    f. What do they think of the decisions and actions taken by the individual being assessed?
6. Questions should be open-ended and not leading. It should not be obvious from the way questions are asked that there is an expected answer.
7. Peers should be coached to consider that there is no single 'correct' answer.

If peers do not endorse or support in any way, the decisions made (or not) and/or actions that an individual took then the assessor may be dealing with actions that were unacceptable. If this is the case, then an assessor may wish to explore further (i.e., double-check) with the peers about their opinions to ensure they were properly understood.

SYSTEM FACTORS GUIDE

System level	System factors
Patient	Possible relevant factors: ▪ Patient identification ▪ Personal characteristics ▪ Important conditions the patient had ▪ Medications the patient was taking (prescription, over-the-counter, herbal) ▪ Important decisions and actions taken by the patient
Personnel ▪ individual being assessed ▪ other personnel ▪ team, if there was one	Possible relevant factors: ▪ Physical characteristics and professional characteristics ▪ Training or experience ▪ Workload, rostering/scheduling/call ▪ Tasks the individual was required to undertake, and the requirements for them ▪ Personal physical and training requirements to complete the task ▪ Generally accepted standards of practice and whether they were met ▪ Possible impairment due to a medical condition and/or recent use of alcohol or drugs Make notes about the team. In addition to the above, other relevant factors may be: ▪ Team formation – experience and training of team members ▪ Team leadership – management, direction, supervision
Environment/ Equipment	Possible relevant factors: **Environment** ▪ Design/construction of the environment(s) where activities related to patient care took place (e.g. space/ physical lay-out, lighting, ventilation, temperature, noise, busyness) ▪ Planned/scheduled housekeeping or maintenance of the environment ▪ Purpose/planned use of the environment ▪ The effect the environment had on how care was delivered

Environment/ Equipment (continued)	**Equipment** ▪ The design, manufacture or maintenance of the equipment ▪ Planned introduction of the equipment (e.g. with orientation/training or standard replacement) ▪ Planned use of the equipment ▪ Planned supply of equipment ▪ Maintenance of the equipment
Organization	Possible relevant factors: ▪ Policies, procedures (standards) and manuals ▫ Available/understandable/usable ▫ Relevant/accurate/up to date ▫ Any conflict with other organizational policies ▪ Communication channels - sharing information ▫ Available/used ▪ Funding/budget goals and priorities
Regulatory Agencies	Possible relevant factors: ▪ Policies, procedures (standards) and manuals ▫ Available/understandable/usable ▫ Relevant/accurate/up to date ▫ Any conflict with other regulatory policies or with organizational policies ▪ Communication channels - sharing information ▫ Available/used ▪ Funding/budget goals and priorities

SYSTEM FACTORS TABLE: TEMPLATE

System level	System factors
Patient	▪
Personnel ▪ individual being assessed ▪ other personnel ▪ team, if there was one	Individual ▪
	Other personnel ▪
	Team ▪
Environment/ Equipment	Environment ▪

Environment/ Equipment	Equipment ▪
Organization	▪
Regulatory Agencies	▪

Problems Identification Table

Individual being assessed:

▪

Event description:

▪

PROBLEMS IDENTIFICATION TABLE: EXAMPLE

Specify Problems (what was done or not done) [Include date and time]	**Suggested Options** (What could or should have been done or not done)	**Vital difference?** (Difference led directly to the event? Probably or Probably not)

Motivation for Noncompliance Questions

Based on the information included in the **System Factors Table**, which includes information from chart reviews and interviews:

Part I – Was there an acceptable opportunity for benefit?
Are there good reasons to believe the actions taken by the individual, had a reasonable chance of benefiting the patients?

☐ **Yes:** Motivation was for benefit rather than harm and the chance of patient benefit was reasonable.
Continue to Part II

☐ **No:** Motivation was either to harm the patient or to accept an inappropriate high chance of harming a patient. In either case, the actions were unacceptable. **In this uncommon scenario, the assessor should consider discipline. Involvement of human resources and/or the appropriate regulatory college is recommended.**
The JIA stops.

Part II – Identify the primary intended beneficiary
Who or what was more likely to obtain the **majority** of the benefit from the individual's actions?
(Choose one response)

☐ **Patient**
☐ **The individual** (e.g., financial, saving time, reputation)
☐ **Another part of the system** (e.g., helping another patient, helping a colleague, saving resources)

NOTE: Other parts of the system mean not the patient and not the individual who is being assessed. This could be other patients or co-workers (e.g., not keeping someone waiting), environment/equipment, or the organization (e.g., saving the organization money).

The response will be used with Decision 3 – Tolerable?

Noncompliance Assessment Matrix

Based on the information that has been collected so far, plot a point on the matrix based on:

a) The individual's motivation for noncompliance. See your response in Part II of the Motivation for Noncompliance Questions.

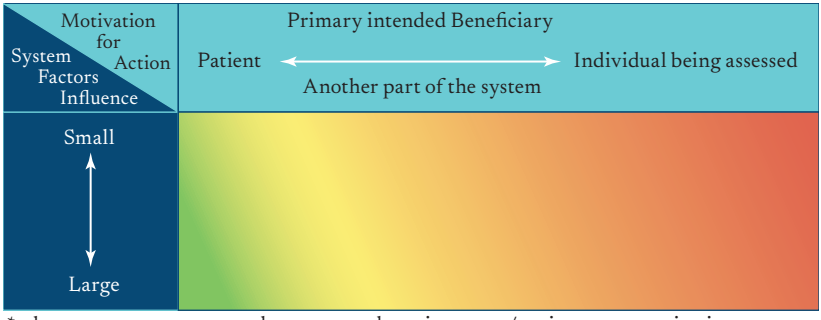
b) The degree to which system factors influenced the individual who is being assessed. This is based on a review of information recorded in the System Factors Table and reflection on how this could have affected choices that the individual made to act or not to act. There are two situations for an assessor to be aware of where the influence of system factors would be considered at least moderate and, in many cases, large:

1. When the individual's decisions and actions/inactions are reasonably in line with how similar people would act, even if it does not adhere to written procedures or standards but rather *it's the way this type of situation or issue is often dealt with in this workplace.*

2. If a system factor unrelated to the individual (e.g., a missing piece of needed equipment) directly interfered with or made it impossible to successfully complete an action.

This will help an assessor with the determination of whether the action or inaction was tolerable or unacceptable. Prior to making this determination an assessor should also check their biases using the Bias Awareness Guide.

Figure. Noncompliance Assessment Matrix



*other system component: other personnel, environment/equipment, organization

COLOUR LEGEND

Green = **Tolerable** – discipline should not be considered

Yellow = **Likely tolerable** – discipline should probably not be considered

Orange = **Potentially unacceptable** – discipline may need to be considered depending on other information and its interpretation

Red = **Unacceptable** – discipline should very likely be considered

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