



Policy

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Applies To:	Team Members	
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PURPOSE

This policy defines Just Culture at Nova Scotia Health and outlines the roles and responsibilities of all Nova Scotia Health Team Members to understand and apply the principles of Just Culture, as a larger part of our Safety Culture.

PRINCIPLES AND VALUES

Nova Scotia Health is committed to fostering a Just Safety Culture while delivering high-quality health care services. To fulfill this commitment, Nova Scotia Health provides the necessary resources, supports, and tools to enable Team Members to understand and apply the principles of Just Safety Culture.

In a Just Culture, the reasons for unexpected clinical outcomes and Patient Safety Incidents are not pre-judged, and the rights of all individuals, including Patients and Team Members, are protected. All are aware of Patient Safety Incident reporting expectations, and when analyzing Patient Safety Incident reports, professional accountability of Team Members is determined fairly within the larger system context. For clarity, Team Members are not accountable for system factors that are beyond their control. To improve the quality and safety of the care that we provide at Nova Scotia Health, it is essential that Patient Safety Incident follow-up is conducted in alignment with the principles of Just Culture as a component of Safety Culture and in alignment with our **Organizational Values:**

Respect

- Nova Scotia Health strives for reporting and follow-up on Patient Safety Incidents to be conducted within a positive and safe environment, with fairness, consistency, respect, compassion, care, and support for Team Members at the heart of the effort.

Integrity

- At Nova Scotia Health, our integrity guides us to do what is honest, ethical, right, and just. This includes evaluating and analyzing our Patient Safety Incidents to identify and take responsibility for organizational and system based contributing factors.

Courage

- At Nova Scotia Health, we aim to have the courage to be transparent in our evaluation of Patient Safety Incidents using a fair and consistent approach, using a process that Team Members can trust.
- We want Team Members to feel enabled, empowered, and supported to have the courage to openly identify, discuss and report Patient Safety Incidents and know that these will be handled fairly using this Just Culture approach.

Innovation

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- Creative solutions and opportunities to create excellence in health care are embraced at Nova Scotia Health to enhance the quality of Patient care and Patient safety while promoting our Patient Safety Culture.

Accountability

- Organizational Accountability: At Nova Scotia Health, we aim to hold ourselves as an organization, our systems, and each other accountable to learn from our mistakes to improve Patient safety for all.
- Individual accountability: Patient Safety Incidents are evaluated in consideration of the circumstances and context of what occurred.

KEY DEFINITIONS

<p>Just Culture</p>	<p>An important part of Safety Culture, where the reasons as to why an unexpected outcome or Patient Safety Incident occurred are not pre-judged and Team Members are not blamed for system factors or outcomes that are outside of their control. In a Just Culture, Patient Safety Incidents are reviewed to understand the reasons why the Incident occurred with the goal of identifying all the factors that contributed to the outcome, including factors that may be related to the larger complex health care system. Although Team Members are not held accountable for system factors that contributed to the Patient’s outcome, Team Members are held appropriately accountable for their behavioural choices and practices within the system.</p>
<p>Leader</p>	<p>The health services manager or director with accountability for the Team Member who was directly involved in the reported Patient Safety Incident, or who provides operational oversight and accountability for the department/program/area in which the reported Incident occurred.</p>
<p>Patient Safety Incident</p>	<p>An event or circumstance which could have resulted or did result in unnecessary harm to a Patient.</p>
<p>Safety Culture</p>	<p>The collection of perceptions, attitudes, values, norms, and beliefs that leaders and staff share about risk and safety for all with Nova Scotia Health.</p> <p>Safety culture can be viewed as comprising of six elements:</p> <p>Reporting Culture: Confidence to report safety concerns without fear of blame.</p> <p>Learning Culture: Ability to learn from mistakes and make changes.</p> <p>Informed Culture: Collect, analyze, and share relevant data and information.</p> <p>Flexible Culture: Capable of adapting effectively to changing demands.</p>

	<p>Just Culture: Reporting, informed, learning. Where the reasons as to why an unexpected outcome or Patient Safety Incident occurred are not pre-judged and Team Members are not blamed for system factors or outcomes that are outside of their control.</p> <p>Restorative Culture: Meaningful connections with the people involved in the incident, including patients and families and NS Health team members, in the pursuit of the resolution of and repair of harms.</p>
System Factors	Things that influence the overall health care system which includes many things, such as work environment contexts, policies, processes, culture, people, and resources.
Team Members	Refers to all employees, physicians, learners, volunteers, board members, contractors, contract workers, franchise employees, and those with affiliated appointments and other individuals performing activities within Nova Scotia Health.

POLICY

1. Team members must use a Just Culture approach to all patient safety incident analysis activities including investigations, response and follow up to patient safety incidents.
 - 1.1. Reporting of Patient Safety Incidents must follow the process laid out in [NSHA AD-QR-015 Patient Safety Incident Management](#).
 - 1.2. When a Patient Safety Incident occurs, Team Members actions must be assessed fairly, using a Just Culture approach with consideration for how the larger system factors may have led to or contributed to the Patient Safety Incident. All Incidents are reviewed with the goal of understanding what led to the Incident, with intentional review of the context, including where and when the Incident occurred.
 - 1.3. The analysis of Patient Safety Incidents must include the consideration of racism and discrimination as a contributing factor, in alignment with the Nova Scotia Health Equity Framework, to identify and address EDIRA (Equity, Diversity, Inclusion, Reconciliation, And Accessibility) related Patient harm within Nova Scotia Health.
2. Patient Safety Incident analysis must include and consider all the tests and factors that inform the [Just Culture Guide](#):
 - 2.1. Context of work and work environments
 - 2.2. Policies, Procedures, Governance
 - 2.3. Foresight test
 - 2.4. Training supervision requirements
 - 2.5. Substitution test

- 2.6. Deliberate harm test
- 2.7. Health test
3. Team Members are held appropriately accountable for their behaviour and their choices. To determine the most appropriate follow-up using the Foresight test, all Nova Scotia Health leaders will review Patient Safety Incidents involving their direct reports to determine the most appropriate follow-up:
 - 3.1. Human error (not intentional or intended):
 - 3.1.1. The leader(s) is responsible to collaborate with Interprofessional Practice and Learning (IPP&L), People Services, and/or Medical Affairs and Medical Leadership, if additional training, performance management, competency assessments, changes to role, or increased supervision are required.
 - 3.1.2. Further analysis of the Incident is required to identify system level recommendations to improve safety for future Patients by the operational leadership team, physician leaders, and Quality Improvement & Patient Safety (QIS) department.
 - 3.2. At-risk behaviour:
 - 3.2.1. At-risk behaviour is any of the following, where the Team Member:
 - 3.2.1.1. Does not recognize the risk of harm to the Patient.
 - 3.2.1.2. Does not understand the risk of harm.
 - 3.2.1.3. Does not believe the risk is significant.
 - 3.2.1.4. Feels the risk is justifiable.
 - 3.2.2. The leader(s) is responsible for considering if there were continuous reckless or at-risk behaviours demonstrated by this Team Member, follow-up with IPP&L, People Services, and/or Medical Affairs and Medical Leadership, and follow organizational guidance for appropriate management action.
 - 3.3. Drift, or normalization of deviation (Team Members are “drifting” away from recognized standards of practice and that becomes normalized or routine over time):
 - 3.3.1. The leader(s) is responsible to consider if normalization of deviation is occurring in their work environment as part of the substitution test.
 - 3.3.2. If normalization of deviation is identified, the leader(s) is responsible to implement larger level education, communication, and interventions to address the practice and correct the drift.
 - 3.4. Reckless behaviour (the Team Member understands the risk of harm and there is conscious disregard of risk of harm):

- 3.4.1. The leader(s) is responsible to consider if there are continuous reckless or at-risk behaviours demonstrated by this Team Member, follow-up with IPP&L, People Services, and/or Medical Affairs and Medical Leadership, and follow organizational guidance for appropriate management action.
- 3.5. Intent to harm (the Team Member knowingly caused harm or the purpose was to cause harm):
 - 3.5.1. The leader(s) is responsible to follow-up with People Services and/or Medical Affairs and Medical Leadership and follow organizational guidance for appropriate management action. This could involve college notifications, referral to law enforcement, and disciplinary processes, in consultation with Privacy and Legal Services as appropriate.
 - 3.5.2. Investigation by the leader(s) in collaboration with People Services and/or Medical Affairs and Medical Leadership is required to understand how and why Patients were not protected from the actions of the Team Member.
- 3.6. Health Test (the Team Member demonstrated impaired practices due to substance misuse and/or mental health issues or physical conditions):
 - 3.6.1. The leader is responsible to follow-up with People Services, Occupational Health, Safety and Wellness, and/or Medical Affairs and Medical Leadership and follow organizational guidance for health issues affecting work.
 - 3.6.2. Leaders, in collaboration with People Services, Occupational Health Safety and Wellness, and/or Medical Affairs and Medical Leadership are required to use a Trauma Informed approach in understanding if health issues could have been recognized and addressed earlier.
4. Just Culture Principles documents are made available to all Team Members by Nova Scotia Health Quality, Improvement and Safety (QIS) to help identify system level accountability in response to Patient Safety Incidents. All leaders are responsible to ensuring that Team Members under their direction are aware of, and familiar with the Just Culture documents.
5. Quality, Improvement and Safety is responsible to provide education to all Team Members to champion Just Culture to support safety for all.
6. Quality, Improvement and Safety will evaluate the Nova Scotia Health Just Culture approach on a regular basis to determine whether it is meeting the needs of the organization in promoting a larger Safety Culture.

ROLES AND RESPONSIBILITIES

Team Members:

- o Complete education on Just Culture, which is provided by Nova Scotia Health, accessible via the Learning Management System (LMS), annually.

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Leaders:

- o Recognize, address, and strive to continuously improve system factors, as they are identified.
- o Patient Safety Incident follow-up and managing Incidents involving their Team Members, as well as those reported Incidents that occur within the department/program/area for which they have operational oversight and accountability.
- o Respond to the behavioural choices and actions of Team Members in a way that is fair, consistent, and just.
- o Respond to Patient Safety Incidents in a way that is free from racism and discrimination, in alignment with the Nova Scotia Health Equity Framework.

All Leaders and Team Members:

- o Help to create and sustain a Just Culture where everyone feels safe to report Incidents, using a consistent, safe, and just process.
- o Follow the processes and tools outlined in this policy and treat everyone with respect and compassion. This promotes a Just Culture throughout the organization and consistency in Patient Safety Incident response.

COMPLIANCE WITH THIS POLICY

- o Compliance with this policy is a condition of employment and privileges. Non-compliance may lead to disciplinary action or other consequences.

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RELATED DOCUMENTS

Policies

[Patient Safety Incident Management policy](#)

[Quality Review policy](#)

[Disclosure of Patient Safety Incidents policy](#)

[Serious-Reportable-Event-Interim-Reporting-Policy.pdf \(novascotia.ca\)](#)

[Respectful Workplace - Policy and Procedure - NSHA AD-HR-020](#)

[Violence in the Workplace - Policy - NSHA AD-OHS-010](#)

[Drugs and Alcohol in the Workplace - Policy and Procedure - NSHA AD-OHS-025](#)

[Abuse Prevention and Response Policy and Procedure](#)

Procedures

[Disclosure of Patient Safety Incidents - Procedure - NSHA AD-QR-010.01](#)

[Quality Review - Procedure - AD-QR-005.01](#)

[Patient Safety Incident Management - Procedure - NSHA AD-QR-015.01](#)

Other

[Just Culture Guide](#)

Appendices

Appendix A: Definitions

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Just Culture	An important part of Safety Culture, where the reasons as to why an unexpected outcome or Patient Safety Incident occurred are not pre-judged and Team Members are not blamed for system factors or outcomes that are outside of their control. In a Just Culture, Patient Safety Incidents are reviewed to understand the reasons why the Incident occurred with the goal of identifying all the factors that contributed to the outcome, including factors that may be related to the larger complex health care system. Although Team Members are not held accountable for system factors that contributed to the Patient's outcome, Team Members are held appropriately accountable for their behavioural choices and practices within the system.
Leader	The health services manager or director with accountability for the Team Member who was directly involved in the reported Patient Safety Incident, or who provides operational oversight and accountability for the department/program/area in which the reported Incident occurred.
Patient	All individuals including clients, residents, and members of the public who receive or have requested healthcare or services from Nova Scotia Health and its Health Care Providers.
Patient Safety Incident	An event or circumstance which could have resulted or did result in unnecessary harm to a Patient.
Safety Culture	<p>The collection of perceptions, attitudes, values, norms, and beliefs that leaders and staff share about risk and safety for all with Nova Scotia Health.</p> <p>Safety culture can be viewed as comprising of six elements:</p> <p>Reporting Culture: Confidence to report safety concerns without fear of blame.</p> <p>Learning Culture: Ability to learn from mistakes and make changes.</p> <p>Informed Culture: Collect, analyze, and share relevant data and information.</p> <p>Flexible Culture: Capable of adapting effectively to changing demands.</p> <p>Just Culture: Reporting, informed, learning. Where the reasons as to why an unexpected outcome or Patient Safety Incident occurred are not pre-judged and Team Members are not blamed for system factors or outcomes that are outside of their control.</p> <p>Restorative Culture: Meaningful connections with the people involved in the incident, including patients and families and NS Health team members, in the pursuit of the resolution of and repair of harms.</p>

Safety Improvement & Management System (SIMS)	<p>The Nova Scotia Health province-wide reporting and management information system used to enhance the capability of Health Care Providers to improve safety. The electronic Patient Safety Incident reporting system was developed with processes to report, analyze, recommend actions, and monitor improvements.</p>
System Factors	<p>Things that influence the overall health care system which includes many things, such as work environment contexts, policies, processes, culture, people, and resources.</p>
Team Members	<p>Refers to all employees, physicians, learners, volunteers, board members, contractors, contract workers, franchise employees, and those with affiliated appointments and other individuals performing activities within Nova Scotia Health.</p>
Trauma Informed Care/Response	<p>Trauma Informed: Trauma Informed in the context of its use in policy means that the overall intention/outcome of the policy is aligned with the theory and principles of Trauma Informed Care. The principles of Trauma Informed Care are Safety, Trustworthiness, Choice, Collaboration and Empowerment. Trauma Informed Care is a universal, systematic, strengths-based service delivery approach that is rooted in an understanding of and responsiveness to the impact of trauma that emphasizes physical, psychological, cultural and emotional safety for both providers and clients. Being Trauma Informed includes recognition of signs and symptoms of trauma in Patients, families and staff along with responses that integrate knowledge about trauma into policies, procedures and practices (Hopper, Bassuk, & Olivet, 2010, Fallot & Harris, 2009, IWK Health Center, 2019).</p>

VERSION HISTORY

Version:	Effective:	Approved by:	What's changed:
Original	2026-03-03	Clinical Operations Council	N/A
Editorial Revision	2026-03-03	NZ Director, Quality and Patient Safety	Link to Just Culture Guide, removed as appendix



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