ATTACHMENT II

California Correctional Health Care Services

Performance Improvement Culture Statement

Patient safety is the fundamental responsibility of every individual in the correctional health care delivery system. To promote an effective performance improvement program, CCHCS actively cultivates a culture of continuous learning and improvement where all staff focus on making health care delivery processes and outcomes as safe and effective as possible and developing and implementing systems that support sustainable, high-quality performance.

CCHCS recognizes that . . .

- Human error is inevitable and we continually strive to monitor and improve systems to prevent errors.
- Most incidents of unfavorable variances from expected patient care involve process or system breakdowns that must be addressed before performance can reliably improve.
- A punitive environment does not fully take into account systems issues, nor does a blame-free environment hold individuals appropriately accountable.
- A culture of learning and improvement recognizes that people operate within processes and systems and can make mistakes; acknowledges that even competent people can develop erroneous patterns of behavior, yet has zero tolerance for reckless behavior, blameworthy acts and delayed reporting of care incidents.
- To effectively identify opportunities for improvement and resolve system problems, CCHCS staff at all reporting levels must be able to report care incidents without being subject to unjust punitive investigation and penalties.

CCHCS staff will . . .

- Support a learning environment that encourages and fosters the reporting and review of all errors, near-misses, adverse events, and system weaknesses.
- Critically analyze existing processes to proactively identify potential problem areas and opportunities for improvement.
- Proactively analyze processes, design and improve systems to support a safe patient care environment.
- Promote collaboration across ranks and disciplines to find sustainable solutions to patient safety issues.
- Respond quickly and reasonably to actions, decisions, and behaviors that may result in unsafe acts, realizing that most actions, decisions, and behaviors do not warrant corrective or adverse action. The most severe penalties, such as demotion, reduction in pay, suspension with or without pay, and termination, are reserved for reckless behavior and blameworthy acts and, as warranted, delayed reporting.
- Report discovered patient care incidents within the timeframes prescribed in relevant Policies and Procedures.
- Use standardized algorithms based upon learning and improvement concepts to determine individual accountability.

A Blameworthy Act . . .

Although performance improvement processes will primarily target the identification and resolution of process breakdowns, reckless behavior and blameworthy acts discovered in this context will be appropriately addressed to ensure patient and staff safety. Reckless behavior includes situations in which an individual takes a substantial and unjustifiable risk that may result in patient harm. A blameworthy patient care act possesses one of the following three characteristics: it involves a criminal act, a purposefully unsafe act, or events involving patient abuse of any kind. Reckless behavior, a blameworthy act, intentionally withholding information, or providing misleading or false information may result in adverse action in accordance with the Disciplinary Matrix.