



COLLABORATIVE JUST CULTURE[®] PROGRAM (CJCP) QUALIFICATION STANDARD

Version 24-2



SG Collaborative Solutions, LLC

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Westlake, TX 76262

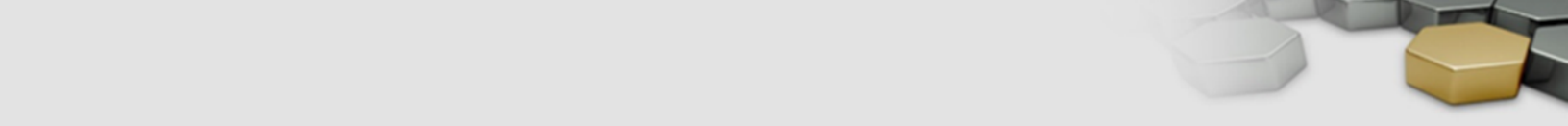
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ABOUT SG COLLABORATIVE SOLUTIONS, LLC



Scott Griffith Collaborative Solutions, LLC (dba SG Collaborative Solutions, LLC) is an enterprise standards and risk management firm specializing in reliable performance in high-consequence industries and organizations. The firm developed the world's first independently audited high reliability standards:

- 1) Collaborative Just Culture® Program (CJCP) Qualification; and
- 2) Collaborative High Reliability® Organization (CHRO) Certification.¹

Contact SG Collaborative Solutions for information on consulting, training, platform, and licensed-affiliate solutions to meet these standards:

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INDEPENDENT THIRD-PARTY AUDITS

SG Collaborative Solutions licenses Innovative Auditing Solutions, LLC to utilize CJCP and CHRO standards for the purpose of independent, conflict-free verification and audits.

For information about Innovative Auditing Solutions contact: tallen@innovativeauditing.com

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- 1) Leader/Mentor;
- 2) Process Facilitator;
- 3) Fact-Gatherer;
- 4) Instructor;
- 5) Consultant/Examiner; and

¹ The Collaborative Just Culture Program qualification is a prerequisite to applying for the Collaborative High Reliability Organization Certification.



6) Auditor (must be a qualified, licensed Auditing Organization) (AO)).

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ACKNOWLEDGEMENTS

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- **John Overton, MD**, former NTSB Chief Medical Officer and Commission on Accreditation of Medical Transport Systems (CAMTS) Board Member;
- **Jack Cox, MD**, Senior VP & Chief Quality Officer for Providence St. Joseph Health (PSJH) (retired);
- **Bryan Burns, BS**, President and CEO, Air Charter Safety Foundation;
- **Kimberly S. Kunkler, Ph.D., ABC-FD**, Assistant Professor, Forensic Science Graduate Program at Marshall University; and
- **Tammy Allen, RN, MSN**, President, Innovative Auditing Solutions, LLC.

DOCUMENT CONTROL AND REVISION HIGHLIGHTS

Collaborative Just Culture® Program Qualification Standard, Version 24-2

Effective Date: September 28, 2024

This revision includes the following updates from the previous version:

- Innovative Auditing Solutions, LLC acknowledged as the licensed auditor of the CJCP standard for purposes of independent, conflict-free verification and audits.

To notify SG Collaborative Solutions of document errors and/or to provide feedback, please contact us at:

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An Introduction to Collaborative High Reliability®



A NEW EVIDENCE-BASED AND EVIDENCE-PRODUCING STANDARD

The more risks an organization sees, understands, and manages *before* accidents occur, the greater the chances of prevention. Organizations won't reach high reliability investigating adverse events alone. A more systematic, proactive approach is needed. There's an evidence-based approach to accomplish this goal.

Since the early days of Edwards Deming's pioneering work in the mid-twentieth century, organizations have aspired to higher levels of performance through quality improvement. By balancing the competing priorities of customer expectations, product delivery, cost and efficiencies, the quality management philosophy revolutionized automobile manufacturing. By focusing on process improvements, quality methods guided organizations to document, monitor, and measure, which produced better results. Other industries soon followed.

But all industries are not the same, and not all have achieved success through quality methods alone. Hospitals, airlines, emergency medical services, firefighting, law enforcement organizations, and the energy sectors, to name a few, operate in distinct environments from automobile manufacturers. These industries – often referred to as high-consequence – grappled with unique challenges requiring siloed solutions: specialized operational departments, regulatory compliance, risk management, information technology, performance improvement, and safety departments were required to help such high-consequence industries stay in business and avoid catastrophe.

Since all organizations engage people, human resource departments arose to address the challenges of managing the workforce. In the late 1990s, just culture gained popularity as a human resources philosophy, using an algorithm to categorize employee behaviors with an aspiration to improve workplace culture. However, just culture came with its own challenges – how to ensure consistent organizational response using a complex tool subject to unreliability? Sometimes cultures improved, many times they did not.

Subsequently, industries turned attention to the term *high reliability organization, or HRO*, in hopes of achieving yet another level of improvement. Organizations compared themselves to aircraft carriers and nuclear power plants to achieve desired levels of performance. Naval ships and power plants are the products of sophisticated engineering system design. The focus of their reliability is technical, or system-based defenses-in-depth. Healthcare, by contrast, evolved separately from the engineering sciences and requires many more individual points-of-delivery, each carrying a potential for harm. Healthcare requires human-centered care, on the delivery and receiving ends. As a result, healthcare poses a different set of challenges. All industries do.

Notably adding to these challenges is that consistent definitions and standards have not been established: *What is just culture? What is high reliability?* Without answers to these questions, organizations have struggled to achieve and replicate results. One-and-done training; individual certifications without currency or proficiency evaluations; and an array of unaligned activities have not yielded consistent outcomes from one industry to the next.

An integrated science has emerged to answer these questions and challenges,² giving rise to a new evidence-producing set of standards and taxonomy known as Collaborative High Reliability®. Developed by SG Collaborative Solutions over decades of work in high consequence industries – including aviation, healthcare, the rail industry, emergency medical services, firefighting, law enforcement, and the energy sectors – this approach builds on the following evidence-based successes:

² Griffith, K. Scott. *The Leaders' Guide to Managing Risk: A Proven Method to Build Resilience and Reliability*. New York, New York: HarperCollins Leadership, November 7, 2023. (<https://leadersguidetomanagingrisk.com/>)

- The US airline industry's highly successful Aviation Safety Action Program (ASAP) and other safety management system programs³;
- The integration of engineering and behavioral sciences with legal and ethical systems of justice; and
- ISO 9001 and quality management principles.

SG Collaborative Solutions combined the common lessons learned across multiple high consequence industries with the specific initiatives identified as best practices within each organization. The result is a new standard and taxonomy representing the latest advances in socio-technical science, building on the organization's quality management experience.

The SGCS CHRO standards and taxonomy define the terms Collaborative Just Culture and Collaborative High Reliability and provide a means to achieve success in any organization. This approach is documented, monitored, and measured – consistent with quality management principles. Most importantly, CHRO is also aligned and integrated with an organization's quality management system to produce sustainable, high reliability results.

CHRO qualifications and certifications offer quantifiable answers to the questions *What is just culture? What is high reliability?* and provide independent, proficiency-based audit verification of organizational achievement. As the developers of CHRO, SG Collaborative Solutions is committed to supporting the continual sustainment and improvement of organizational quality, safety, and high reliability.

THE WHY

Perhaps the first question for any organization to ask and answer is: *Why dedicate the time and resources necessary to achieve the Collaborative High Reliability® Organization Qualifications and Certification?* While answers may be different for each organization, the most common responses to this question include the following:

- Achieve reliability across all organizational attributes;
- Prevent failures and adverse events – reducing claims and lowering awards;
- Enhance relationships with customers, regulators, and other stakeholders;
- Optimize assets and resources;
- Improve employee morale and cultural cohesiveness;
- Reduce burnout and raise retention;
- Gain competitive advantages;
- Ensure long-term sustainability; and
- “It’s the Right Thing to Do.”

³ In the US commercial aviation industry, these early applications contributed to a 95% reduction in the fatal accident rate between 1998 and 2018. https://www.faa.gov/news/fact_sheets/news_story.cfm?newsId=22975, published August 2, 2018.



DEFINITION AND KEY BENEFITS OF A COLLABORATIVE JUST CULTURE PROGRAM

A Collaborative Just Culture is a program to help achieve high reliability through workplace justice and collaboration and is defined by:

- Evidence-based standards;
- Documentation, monitoring, and measurements; and
- Independent, proficiency-based audits by a qualified, licensed third-party.

Key evidence-producing benefits of a CJCP include, but are not limited to:

- Increased employee risk reporting (compared to event reporting);
- Better individual and organizational management of risk;
- Improved employee job satisfaction; and
- Lower risk of employee burnout and turnover.

THE SEQUENCE OF RELIABILITY™

Becoming highly reliable requires a scientific understanding of how organizations operate and produce results. Organizations are socio-technical entities. (The term *socio-technical* means people working with and inside systems.) To understand and optimize this complex relationship, the organization must start by seeing and understanding risk and recognizing how the risk is perceived by individuals, teams, and the organization at large.

The Collaborative High Reliability® model and taxonomy start with applying the socio-technical science in a specific order, known as The Sequence of Reliability™. This sequence provides the foundation by which CHRO produces and sustains organizational improvement. The Sequence of Reliability is:

- 1) First, See and Understand Risk, then
- 2) Manage Reliability in this Order:
 - a. **System** (to become effective and resilient);
 - b. **Human** (both human performance and human behavior); and
 - c. **Organization** (achieve sustainment and become predictive).

ATTRIBUTES OF COLLABORATIVE HIGH RELIABILITY ORGANIZATIONS (CHRO)

While many models of organizational high reliability prioritize safety as the primary (or exclusive) focus, CHRO produces high reliability in multiple key areas, described as organizational attributes. These attributes – where unreliability could jeopardize the organization's mission – are essential to high reliability:

- **Safety** – Safety encompasses the physical, psychological, and emotional well-being of customers/patients, staff, and visitors, as well as the protection of property;

- **Equity** – Equitable treatment of customers, staff, and visitors – including diversity and inclusion initiatives – is essential to organizational reliability;
- **Customer Service** – Customer services must align with customer expectations, balanced against available resources. In healthcare, this attribute includes compassionate care; in aviation, customers may expect on-time performance and baggage delivery. In emergency management services, response time is critical in meeting customer expectations and business requirements;
- **Privacy** – Privacy protection is important in all business endeavors – for customers/patients, staff, and visitors. Examples include personal financial and employment records, protected health information defined by the Health Insurance Portability and Accountability Act (HIPAA), and other forms of personal data;
- **Quality** – Quality can be described as the relationship between customer expectation, product delivery, and cost. Quality Management principles include the requirement to document, monitor, and measure organizational performance;
- **Operational Integrity** Operational integrity includes staffing, supply chain management, information systems security, as well as other infrastructure requirements to complete an organization's mission; and
- **Financial Responsibility** – All organizations – for-profit and not-for-profit alike – require financial responsibility to operate.

A SOCIO-TECHNICAL, MULTI-DISCIPLINED APPROACH

Organizations are socio-technical – comprised of people and systems. The language used to describe organizational improvement has evolved from multiple disciplines, including:

- **Engineering-based industries** (e.g., manufacturing; the energy sectors; and aviation);
- **Behavioral sciences** (e.g., human factors psychology; team-based endeavors such as firefighting and certain military operations); and
- **Legal systems of justice** (e.g., criminal and civil courts; regulatory oversight agencies).

In the past, organizational improvement initiatives led to a complex and, at times, confusing set of terms. Many terms have different meaning in different situations. For example, an engineer might refer to a system as a collection of parts designed and manufactured to a set of standards serving a function and producing an output; a behavioral scientist might describe a system as a set of processes, procedures, and responsibilities; a lawyer might describe the same system using words such as duty, breach, and liability. Within CHRO, terms such as *system* and *program* require common understanding and points of reference.

A HIERARCHY OF TAXONOMY TERMS

To understand, monitor, and measure reliability, CHRO provides a hierarchy of taxonomy terms:

- **Activity** – actions that are usually not documented (e.g., practices);
- **Process** – a documented set of activities (e.g., procedures, checklists, methods, etc.);
- **Program** – a documented alignment of related processes and/or other components;

- **System** – a documented alignment of programs, processes, and/or other components; and
- **Integrated System** – a documented coordination of aligned systems, programs, policies, processes, and/or other components.

Note: The terms *policy*, *project* and *plan* are descriptors used to document timelines and scope in the development of activities, processes, programs, systems, and integrated systems. While these are important terms that may be used often, they are not included as part of this hierarchy of taxonomy terms.

Figure 1 below illustrates the features in the CHRO hierarchy of taxonomy terms:

Taxonomy Term	Feature			
	Undocumented	Documented, Monitored, & Measured	Aligned	Integrated
Activity	✓			
Process		✓		
Program		✓	✓	
System		✓	✓	
Integrated System		✓	✓	✓

Figure 1

This hierarchy of terms is necessary to provide a common understanding of the essential components of CHRO®. It is important to describe the purpose and function of each term. Seeing and understanding the distinctions in the hierarchy will assist organizations in monitoring and measuring progress.

In an integrated system, all components shall function in relation to the other components to support the purpose of the system. Integrated components shall coordinate and overlap with other components. (e.g., policies describing Risk, Quality, Safety, Performance Improvement, and Human Resources programs must describe fact-gathering, analyses, and organizational response to risk and events relevant to the purpose and output of the system.)

DOCUMENT, MONITOR, MEASURE, ALIGN, AND INTEGRATE

In CHRO, an integrated system must be more than a collection of components. The components must be documented, monitored, measured, aligned, and integrated.

Document – Committing a process, policy, program, system, or integrated system to a written record. Documentation shall be widely and easily accessible to individuals and teams relying on its guidance and to those serving oversight roles and responsibilities.

Monitor – Reviewing the effectiveness and resilience of a process, policy, program, system, or integrated system.

Measure – Assigning a score or value to the effectiveness and resilience of a process, policy, program, system, or integrated system.

Align – Ensuring processes, policies, programs, systems, and integrated systems are consistent with CHRO taxonomy and methods and do not directly or indirectly oppose each other.

Integrate – Combining or coordinating aligned processes, policies, programs, and systems into an integrated system.

A key distinction of the CHRO model is the requirement to align and integrate all high reliability initiatives. Consistent with the CHRO hierarchy of terms above, at a minimum, a CHRO organization documents, monitors, measures, aligns, and integrates the following departments and/or functions:

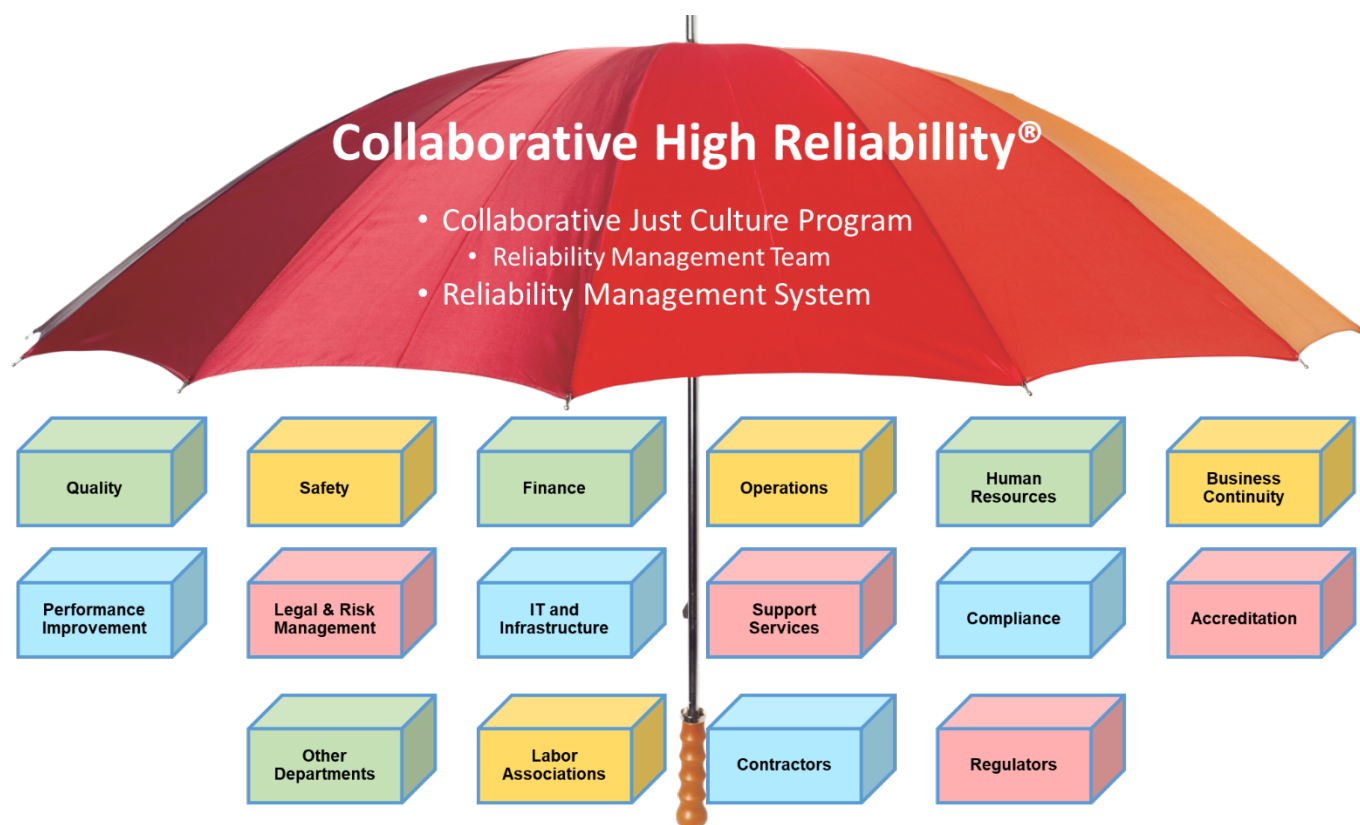


Figure 2

INDIVIDUAL AND ORGANIZATIONAL LEARNING

A Collaborative High Reliability Organization (CHRO) develops the knowledge, skills, abilities, and proficiencies to see, understand, and manage risk – at the individual and organizational levels. CHRO learning extends beyond mere compliance. A CHRO recognizes three levels of training, each with a requirement to maintain currency no less than every two-years.

- Level 1: Introduction to CHRO principles and risk-reporting;
- Level 2: Operational ability to see, understand, and manage risk; and
- Level 3: Proficiency as a role-qualified subject-matter-expert.

A CHRO uses language and principles of reliability throughout the organization – from the chief executive officer to the frontline staff – aligning and integrating the workforce.

THE STEPS TO SUSTAINABILITY: QUALIFICATION AND CERTIFICATION

The path to becoming a Collaborative High Reliability® organization begins with executive leadership commitment to becoming a CHRO and the development of a strategic plan that supports the goal. In alignment with principles of high reliability, SGCS has granted Innovative Auditing Solutions, LLC permission to utilize the CHRO standards for the purpose of independent, conflict-free verification of:

1. **Collaborative Just Culture Program Qualification;** and
2. **Collaborative High Reliability Organization Certification (Tiers 1 through 3).** A multi-year journey to certification is expected, even when the organization has been engaged previously in high reliability activities.

Note: Reliability science has proven the more risks identified and managed before an adverse outcome occurs, the better the chances of prevention. A key distinguishing element of CHRO from any other standard is the focus on seeing, understanding, and managing risk specific to the organization, which relies on a formal risk reporting program. To this end, the Collaborative Just Culture program qualification is an essential prerequisite to achieve the Collaborative High Reliability Organization certification.



Figure 3

BEYOND OTHER STANDARDS

The Collaborative High Reliability® Organization standards require more than quality management or industry-specific recognition programs alone, building on the principles of documenting, monitoring, and measuring to achieve higher levels of sustainable performance over time in any industry. Achieving Collaborative High Reliability Organization qualification and certifications represent the next levels in quality management, extending beyond other approaches such as the [Baldrige Performance Excellence Program](#), the [ANCC Magnet Recognition Program®](#), and [ISO 9001](#) (Quality Management System). Recognition by these standards is not required, but organizations that embrace a leadership driven approach may see value in having met them.



AUDITS DESCRIPTION

Independent Third-Party Validation: CHRO qualification and certification require independent third-party validation that a program, team, or organization has demonstrated compliance with the CHRO Qualification and Certification standards, containing two elements:

- Collaborative Just Culture Program Qualification (to include Reliability Management Team (RMT))
- Collaborative High Reliability Organization Certification (Tiers 1 through 3)

Qualification and Certification audits are:

- **Independent** – A key principle of reliability requires independent, third-party verification of the organization.
- **Currency- and Proficiency-based** – Audits shall verify currency and proficiency (i.e., competency sustained over time). Audits shall occur at defined intervals, but no less frequently than every two years.

When Multiple Audits and Program Qualifications Are Required: Typically, an organization such as a community hospital, manufacturing plant, fire station or aviation charter company will require a single Collaborative Just Culture program audit for its primary facility or campus, provided all employees are subject to a single leadership team and governing body, and single RMT, and a single set of policies and procedures, including all human resources, quality and safety, disciplinary, and code-of-conduct requirements.

However, separate audits may be required to qualify CJC programs where any of the following organizational structures are present:

- Separate Reliability Management Teams;
- Separate facilities with distinct leadership and/or systems, and/or policies;
- Separate governance structure (e.g., non-employed medical staff with bylaws);
- Large organizations with distinct regions; or
- Separate business units with different reporting structures.

In these organizations, Collaborative Just Culture is considered a system, comprised of multiple CJC programs, each aligned and audited to meet the qualification standard.

Audit Resources: The resources the auditor teams use in the CJCP qualification include:

- Documentation review; and
- Individual and team Interviews.

Qualification Audit Frequency: The organization will receive CJCP qualification based on audit findings and acceptable corrective document submissions. CJCP qualification is valid for two (2) years. To maintain qualification, the organization will be subject to biennial (every two years) audits to verify continued compliance with the CJCP qualification and compliance with previous corrective document submissions.



Collaborative Just Culture® Program (CJCP) Qualification Standard



CJC.1 EXECUTIVE LEADERSHIP AND GOVERNING BODY RESPONSIBILITIES

Executive leadership and governing body support is crucial to CJCP success.

QR.1 Executive leadership and the governing body (or organized group or entity who assume full legal authority and responsibility for operations of the organization) are responsible and accountable for:

QR.1a Documenting their commitment to the Collaborative Just Culture® Program (CJCP) in its entirety as required in this qualification standard; and

Guidance:

Executive leadership and the governing body may demonstrate their commitment to the CJCP through any of the following examples: written policy; statement of commitment to the CJCP; a strategic plan that allocates support to the CJCP through allocation of assigned staff and other operational resources.

QR.1b Ensuring individual executive support of the CJCP (relative to their organizational role) is included in annual individual performance evaluations for all executives and departmental leaders (including directors, managers, assistant managers, and supervisors), to be accomplished by the end of the first two-year CJCP qualification period.

Guidance:

Individual executive support may be demonstrated through, but not limited to, any of the following examples: inclusion in SMART (Specific, Measurable, Achievable, Relevant, and Time-Bound) goals; OKRs (Objectives and Key Results); and/or KPIs (Key Performance Indicators).

CJC.2 LABOR ASSOCIATION INVOLVEMENT (WHERE APPLICABLE)

QR.1 Labor association (where applicable) involvement is crucial to CJCP success. For organizations with represented workforce(s), the following shall apply:

QR.1a Labor association leaders shall be invited to participate in the program development and operation, including participation in:

QR.1a(1) Reliability Management Team meetings;

QR.1a(2) Collaborative Risk Reviews;

QR.1a(3) Triad Reviews, when needed; and

QR.1a(4) CJCP internal evaluations.

Guidance:

For example, CJCP description in employment contracts and/or memoranda-of-understanding (MOU) would satisfy the requirement for labor involvement. Other types of involvement could include documented labor participation in Triad Reviews and/or Collaborative Risk Reviews.



QR.1b If labor association leadership declines participation in QR1a, the organization shall document the invitation and encourage labor input and involvement on a regularly recurring basis (e.g., when labor leadership changes, when contracts and MOUs are renegotiated).

CJC.3 RELIABILITY MANAGEMENT TEAM

The organization shall establish a Reliability Management Team as in-house guides to achieve and sustain program qualification. The organization shall ensure the development of and adherence to:

QR.1 A Reliability Management Team Charter:

QR.1a **Purpose:** The purpose of the RMT shall be documented in the charter.

Guidance:

For example, a written statement of purpose is:

"The Reliability Management Team serves as the high reliability subject matter experts responsible for guiding the organization to see, understand, and manage risk and to achieve Collaborative Just Culture program qualification and Collaborative High Reliability organization certification."

QR.1b **Processes:** The RMT charter shall describe, at a minimum, the following:

QR.1b(1) The responsibilities and expected accomplishments of the RMT;

QR.1b(2) Frequency and schedule of RMT meetings; and

QR.1b(3) The organization's response to:

QR.1b(3)(i) Known risks; and

QR.1b(3)(ii) Known events.

QR.1b(4) The organization's proactive risk management activities.

QR.1c **Selection:** The RMT charter shall describe, at a minimum, the selection process of RMT members and SME role-qualified specialists necessary for reliable team administration.

Guidance:

The number of RMTs, their size and makeup, meeting schedules, etc., will vary depending on the organization's size, number of employees, geographic footprint, risk profile, and other factors.

QR.1d **Composition:** The RMT shall consist of a cross departmental and cross functional team representing leaders and frontline staff from various areas of responsibility within the organization. The RMT shall include, at a minimum, representatives from:

QR.1d(1) Human Resources;

QR.1d(2) Quality/Safety/Risk Management;



QR.1d(3) For healthcare organizations, Medical Staff (or those with authority to act on behalf of Medical Staff);

QR.1d(4) Frontline staff engaged in operational delivery (e.g., clinical care, flight operations, firefighting, production, member services, etc.) and/or labor representatives; and

QR.1d(5) Other specialized and non-specialized support services as determined by the organization (e.g., education, support services including, but not limited to logistical, environmental, facilities, and information technology services).

QR.1e **Role-Qualified Specialists:** The organization shall designate and train to proficiency RMT individuals (and other individuals within the organization) to be CJCP subject matter experts (SMEs).

QR.1e(1) The number of role-qualified specialists may vary based on the size and operational needs of the organization but shall be at least the minimum number required to meet the operational needs of the program.

QR.1e(2) Role-qualified specialists must achieve documented qualification by a CHRO Consultant/Examiner other than the one who conducted the training to ensure impartiality and objectivity in the evaluation process.

Guidance:

This separation helps maintain the integrity of the testing process by minimizing potential biases or conflicts of interest that might arise if the instructor were to also conduct the evaluation.

QR.1e(3) The organization shall designate individuals⁴ who are trained-to-proficiency and qualified in the following roles:

QR.1e(3)(i) **Leader/Mentor:** Organizes, manages, and assumes responsibility for CJCP qualification and the RMT's performance; mentors leadership, managers, and supervisors;

QR.1e(3)(ii) **Fact-Gatherer:** Gathers facts and conducts analysis;

QR.1e(3)(iii) **Process Facilitator:** Facilitates Collaborative Risk Reviews and Triad Reviews;

QR.1e(3)(iv) **Instructor**⁵: Provides training on CJCP and CHRO standards; and

QR.1e(3)(v) **Consultant/Examiner**⁶: Serves as an advisor to guide the organization to achieve CJCP qualification, including conducting examinations for the above role-qualifications, provided another qualified Instructor or Consultant conducted the training to ensure impartiality and objectivity in the evaluation process.

⁴ Individuals may hold multiple role qualifications.

⁵ May be outsourced by the organization.

⁶ May be outsourced by the organization.

QR.2 RMT Responsibilities:

The RMT is responsible for:

- QR.2a Documenting RMT members and SME role-qualified specialists selected for reliable team administration;
- QR.2b Maintaining training and currency requirements for each RMT member and SME role-qualified specialist;
- QR.2c Using the Sequence of Reliability to assist the organization in seeing, understanding, and managing risk, through action including, but not limited to:
 - QR.2c(1) Initiating, developing, implementing, and facilitating a Collaborative Risk Review process; as a consistent method to achieve the collaborative management of risk;
 - QR.2c(2) Initiating, developing, implementing, and facilitating a Triad Review process as a consistent method to respond to employees and contractors (including physicians) involved in identified risks and adverse events; and
 - QR.2c(3) Facilitating the use of the CJCP as an organizational response to identified risks.
- QR.2d Ensuring all employees and contractors are trained-to-currency in their organizational roles at the appropriate level in accordance with the CJCP policy;
- QR.2e Assisting in the monitoring and management of risk;
- QR.2f Developing CJCP sustainment plans; and
- QR.2g Ensuring departmental alignment with the CJCP, including, but not limited to the following functions:
 - QR.2g(1) Human Resources;
 - QR.2g(2) Safety;
 - QR.2g(3) Quality;
 - QR.2g(4) Risk Management; and
 - QR.2g(5) Performance Improvement.

CJC.4 POLICY

A Collaborative Just Culture Program policy shall include, at a minimum, the following:

QR.1 **Purpose:** The purpose of the CJCP shall be documented in the program policy.

Guidance:

For example, a written statement of purpose is:



"The Collaborative Just Culture® Program purpose is to help achieve high reliability through workplace justice and collaboration. The CJC program ensures a reliable organizational response to employees and contractors involved in risk and events. The CJCP follows the Sequence of Reliability: Seeing and understanding risk, managing systems, human performance, human behaviors, and organizational sustainment in that order."

QR.2 Risk Escalation Expectations: The CJCP shall include a Risk Escalation Expectation section of the CJCP policy to include the requirement for all employees and contractors to escalate significant risks to the organization in a timely manner, and the pledge for the organization to support good faith risk escalations without reprisal.

Guidance:

For example, a written Risk Escalation Expectation is:

"We expect that every team member, including physicians who may not be directly employed, will face circumstances in the workplace where multiple values and competing priorities exist. When such circumstances occur, it is our expectation that individuals escalate their concerns in a timely manner, up to and including the highest-ranking authority available at the time, whether that authority is near the circumstance or not. Each department is responsible for establishing the processes and procedures supporting such escalation."

We pledge to support any team member and/or physician who escalates a concern in good faith, and we will be guided by the Collaborative Just Culture policy in support of those individuals."

QR.3 Risk Reporting Systems: The CJCP shall include defined and aligned processes for evaluating, analyzing, documenting, monitoring, and measuring risks, in addition to adverse events and near-misses.

Guidance:

Risk reporting systems encourage reports to be submitted long before harm or near-miss events occurs. One way to shift the paradigm is to rename an "event reporting system" as a "risk reporting system."

QR.4 Program Alignment:

QR.4a The organization recognizes the following CHRO attributes supported by the CJCP:

QR.4a(1) Safety;

QR.4a(2) Customer Service;

QR.4a(3) Privacy;

QR.4a(4) Quality;

QR.4a(5) Financial Responsibility;

QR.4a(6) Operational Integrity; and

QR.4a(7) Equity.

QR.4b At a minimum, the following policies/documents, if they exist, shall be aligned with the CJCP policy:

- 
- QR.4b(1) Human Resources policies on employee performance management;
 - QR.4b(2) Human Resources policies on employee behavior management and disciplinary action;
 - QR.4b(3) Employee handbooks;
 - QR.4b(4) Codes-of-Conduct;
 - QR.4b(5) Compliance policies;
 - QR.4b(6) Quality Management;
 - QR.4b(7) Risk Management;
 - QR.4b(8) Safety Management;
 - QR.4b(9) Performance Improvement; and
 - QR.4b(10) Labor contracts and MOUs.

QR.5 Human Performance and Behavior Management:

The organization shall demonstrate that documented guidance is provided for human performance and behavior management, including but not limited to:

- QR.5a Performance Improvement Plans (i.e., remedial, not disciplinary, actions);
- QR.5b Repetitive risk-taking behaviors;
- QR.5c Coaching;
- QR.5d Disciplinary action;
- QR.5e Reassignment;
- QR.5f Termination of employment or contract; and
- QR.5g A Triad Review process.

QR.6 Triad Review process:

A Triad Review process shall be established, monitored, and measured for operational reliability. The Triad Review process shall include, at a minimum:

QR.6a Criteria for identifying threshold events and/or risks requiring a Triad Review;

QR.6a(1) A Triad Review shall be required before initiating any disciplinary action that impacts compensation (e.g. suspension) or permanent record, including termination of employment.

QR.6b Composition, roles, and responsibilities of the Triad Review team members. The following individuals shall be present in a Triad Review:

QR.6b(1) A management representative from the work unit where the risk is identified to provide operational and cultural perspective;

QR.6b(2) A Role-Qualified SME (subject-matter-expert) representative from Human Resources (or other department or committee charged with overseeing organizational response to contractors and/or non-employed physicians) to provide employment law and/or cultural perspective; and

QR.6b(3) A Role-Qualified SME individual trained-to-proficiency (e.g., an RMT member; Safety, Quality, or Risk department representative) to provide a system, environmental, and/or cultural perspective.

Guidance:

In organizations with labor associations, a labor representative is encouraged to provide input to the Triad Review team and may gather further facts associated with the review, as desired.

QR.6c Unanimous Consensus of Agreement – The Triad Review teams shall achieve a *unanimous consensus of agreement* on all findings and recommendations prior to initiation of an organizational response;

QR.6d An Escalation Process – The organization shall establish and document an escalation process in the event a unanimous consensus is not achieved, documenting the specific individual(s) by title or position who will make the final decisions on organizational response; and

QR.6e Documentation – The organization shall maintain documentation of all Triad Review team findings and recommendations, including the organizational response and accomplishment(s).

CJC.5 TRAINING

QR.1 Currency and Proficiency:

All employees and contractors shall be trained-to-currency and/or proficiency at the appropriate level in accordance with the CJCP policy;

QR.1a Training in the fundamentals of CJCP shall occur as part of employee and manager promotion orientation;

QR.1b Sustainment (i.e., currency) training after orientation shall be provided no less frequently than every two years; and

QR.1c A documented process and schedule shall be established for ensuring all employees and contractors are trained (or scheduled to be trained) in accordance with Figure 4 below.

QR.2 Documentation:

The organization shall assign and document the individual responsible for the documentation and maintenance of all training records for the CJCP, including the following for each employee and contractor:

QR.2a Name and position in the organization;

QR.2b Level of training received (see Figure 4); and

QR.2c The time frame for training accomplishment as specified by the organization.

Guidance:

At the time of a qualification audit, new employees, new managers, and employees on leave-of-absence may not all be fully trained, but those untrained shall be scheduled for training upon return to work within a time frame specified by the organization. The audit organization may request follow-up documentation as evidence of training completion.

QR.3 Minimum Requirements:

All employees and contractors shall receive training in accordance with Figure 4 below:

Organizational Role	Minimum Currency Training Requirements (at least every two years)		
	Introduction	Operational Ability	Role Qualification SME Proficiency
Staff	✓		
Contractors (including physicians)	✓		
Senior executives	✓		
Vice-presidents and directors	✓	✓	
Managers/supervisors (including physicians in supervisory and/or quality review roles)	✓	✓	
Role-Qualified Specialists (SMEs such as human resources professionals; safety or quality or risk or performance improvement personnel; Collaborative Risk Review team members; Triad Review Team members; RMT Instructors and Consultant/Examiners)	✓	✓	✓

Figure 4



QR.4 **Introduction Training:**

At a minimum, introduction training shall include familiarity with the CJCP and the importance of risk-reporting, including the following subjects:

QR.4a Identification of risk;

QR.4b Reporting of risk;

QR.4c Avoiding outcome bias;

QR.4d Description of system contributors to risk:

QR.4d(1) Recognizing the difference between system effectiveness and system resilience.

QR.4e Description of Human contributors to risk:

QR.4e(1) Distinctions between Human Performance Management and Human Behavior Management;

QR.4e(2) Human error; and

QR.4e(3) Choices.

QR.5 **Operational Ability Training:**

At a minimum, Operational Ability training shall include all Introduction Training plus the following subjects:

QR.5a Operational ability in the use of the organizational response tools.

QR.5b At a minimum, avoiding the following biases:

QR.5b(1) Personal biases (including, but not limited to those that could lead to mismanagement of risk such as racial, gender, sexual, ethnic, religious, cultural, or political).

QR.5b(2) Outcome;

QR.5b(3) Hindsight;

QR.5b(4) Professional;

QR.5b(5) Manager/Employee;

QR.5b(6) Normalcy;

QR.5b(7) Confirmation; and

QR.5b(8) Fundamental attribution.

QR.5c Recognizing the difference between system and personal influences on human performance and human behavior:



QR.5c(1) System influences (i.e., system performance shaping factors); and

QR.5c(2) Personal influences (i.e., personal performance shaping factors).

QR.5d Recognizing and providing the appropriate organizational responses to:

QR.5d(1) Individuals who are unclear about organizational expectations;

QR.5d(2) Situations where it is impossible for individuals to meet organizational expectations;

QR.5d(3) Justifiable deviations from organizational expectation, policy, rule, or procedure;

QR.5d(4) Human error; and

QR.5d(5) Higher culpable actions.

QR.6 Role-Qualification SME Training:

At a minimum, Role Qualification SME training shall include all Introduction Training plus Operational Ability Training plus;

QR.6a Operational proficiency in the use of the organizational response tools;

QR.6b The specific individual knowledge, skills, abilities, and proficiencies required for the roles needed by the organization for CJCP qualification and sustained operation as specified in CJC.3 QR2.

QR.7 New Employees and Newly Promoted and Appointed Individuals:

The organization shall ensure the following training records are maintained in accordance with Figure 4 for:

QR.7a Newly hired employees; and

QR.7b Newly promoted and appointed individuals.

QR.8 Sustainment (i.e., Currency) Training:

The organization shall ensure biennial (every two years) recurrent training records are maintained and documented for all employees and contractors in accordance with Figure 4 with an emphasis on:

QR.8a Retention and currency of initial training;

QR.8b Lessons-learned from annual internal evaluations; and

QR.8c Continued guidance on how to report and proactively manage risk.

CJC.6 TOOLS

The CJCP tools support the CHRO attributes and guide organizational actions to ensure reliability.

QR.1 Reliable CJCP organizational response tools shall be selected to provide a balanced, sequenced, and guard-against-bias approach to seeing, understanding, and managing risk.



QR.2 The CJCP organizational response tools shall be used:

QR.2a By RMT members during leading Collaborative Risk Reviews;

QR.2b By Safety/Quality/Risk personnel;

QR.2c By managers and supervisors; and

QR.2d In the Triad Review process.

QR.3 All SME Role-Qualification individuals shall be trained to operational proficiency in the use of the organizational response tools.

QR.4 The CJCP organizational response tools shall:

QR.4a Support the CHRO organizational attributes;

QR.4b Organize fact-gathering (e.g., event or risk review, timeline development, interviews);

QR.4c Provide a balanced, unbiased review of system and human reliability;

QR.4d Recognize the difference between system effectiveness and system resilience;

QR.4e Recognize the difference between human performance and human behavior;

QR.4f Provide the appropriate organizational responses to manage system and human contributors to risk:

QR.4f(1) Individuals who are unclear about organizational expectations;

QR.4f(2) Situations where it is impossible for individuals to meet organizational expectations;

QR.4f(3) Justifiable deviations from organizational expectation, policy, rule, or procedure;

QR.4f(4) Human error;

QR.4f(5) At-risk choices;

QR.4f(6) Reckless choices; and

QR.4f(7) Higher culpable choices.

QR.5 The use of the CJCP tools shall be monitored and measured to ensure proficient use.

CJC.7 SUSTAINMENT PLAN AND INTERNAL EVALUATION

QR.1 **Sustainment Plan:** The organization shall document a CJCP sustainment plan to include the following:

QR.1a The organization shall ensure sustainment (i.e., currency) training is conducted and documented in accordance CJC.5 QR8;

QR.1b Each SME role-qualified Leader/Mentor shall develop and document a succession plan; and



QR.1c The organization shall ensure the minimum number of SME role-qualified individuals are in place to meet the operational needs of the program in accordance with the CJCP charter.

QR.2 **Internal Evaluation:** The organization shall specify the process for conducting ongoing measurements and an annual internal evaluation and reporting the results, including the following details:

QR.2a At a minimum, the internal evaluation shall measure:

QR.2a(1) **Fair and consistent treatment of employees** through the separation of Performance Management and Behavior Management using tools and processes as documented by:

QR.2a(1)(i) Organizational use of Performance Improvement Plans, etc.

QR.2a(1)(ii) Employee disciplinary actions for behavior;

QR.2a(1)(iii) Triad reviews; and

QR.2a(1)(iv) All employment terminations.

QR.2a(2) **Collaborative management of system, environmental, and personal risk** through the following processes:

QR.2a(2)(i) Fact-Gathering;

QR.2a(2)(ii) Collaborative Risk Reviews;

QR.2a(2)(iii) Triad Reviews; and

QR.2a(2)(iv) Risk reporting (beyond adverse event and near-miss reporting).

QR.2a(3) **A Perception of Culture survey** documented, monitored, and measured for:

QR.2a(3)(i) Each division or department.

QR.2a(3)(ii) Senior executives/vice presidents;

QR.2a(3)(iii) Directors/managers/supervisors;

QR.2a(3)(iv) Quality/Safety/Risk Performance Improvement departments; and

QR.2a(3)(v) Frontline staff.

QR.2b A documented process on how the organization will track all organizational responses to all findings and recommendations from the internal evaluation.

QR.2c Reporting of the results of the annual internal evaluation of the CJCP, including all findings and recommendations, shall be reported to:

QR.2c(1) Executive leadership; and



QR.2c(2) The governing body (or organized group or entity who assume full legal authority and responsibility for operations of the organization).

QR.2d Reports shall include:

QR.2d(1) Identification of opportunities for improvement;

QR.2d(2) Tracked status of all findings and recommendations; and

QR.2d(3) Summary of accomplishments from tracking of findings and recommendations.

QR.3 **Periodic Review Meetings with Executive Leadership**

QR.3a Representatives from the Reliability Management Team, including but not limited to, Leaders/Mentors and CJCP managers shall meet with executive leadership periodically, but no less than once per quarter, to review ongoing risks identified through:

QR.3a(1) Collaborative Risk Reviews;

QR.3a(2) Triad Review; and

QR.3a(3) Ongoing internal evaluations.

QR.4 **Annual Reports to the Governing Body**

QR.4a A report to the Governing Body shall be made no less than annually summarizing the findings, recommendations, and results of the annual internal evaluation, including:

QR.4a(1) Fair and consistent treatment of employees;

QR.4a(2) Collaborative management of system, environmental, and personal risk; and

QR.4a(3) A Perception of Culture Survey.



APPENDIX A –

Model Collaborative Just Culture® Program Policy



PURPOSE

Collaborative Just Culture Program (CJCP) is a documented program to assist ORGANIZATION in achieving sustainable reliability through workplace justice and collaboration. CJCP supports our commitment to multiple attributes that make ORGANIZATION a highly reliable organization, including, but not limited to: Safety (this includes the physical, psychological, and emotional well-being and security of patients, team members, contractors, and visitors); Customer Service; Privacy; Quality; Quality; Financial Responsibility; Operational Integrity; and Equity.

CJCP provides guidance for the identification and management of risk in accordance with the Sequence of Reliability:

- 1) First, See and Understand Risk, then
- 2) Manage Reliability in this Order:
 - a. **System** (to become effective and resilient);
 - b. **Human** (both human performance and human behavior); and
 - c. **Organization** (achieve sustainment and become predictive).

CJCP includes defined and aligned processes for evaluating, analyzing, documenting, monitoring, and measuring risks, in addition to adverse events and near-misses. (See Collaborative Risk Review Policy and manual).

In accordance with high reliability principles, the ORGANIZATION CJCP is continuously⁷ documented, monitored, and measured for effectiveness, and is examined independently every two years by Innovative Auditing Solutions, LLC for program qualification under Collaborative High Reliability (CHRO) standards.

ORGANIZATION COMMITS TO:

- A proactive, preventative approach to seeing, understanding, and managing risk;
- Continuous improvement of systems, policies, processes, and procedure:
- Provide team members and physicians with the systems, tools, processes, education, and training to perform their duties to the best of their abilities;
- Provide clear expectations of how to see, understand, and manage risk;
- Utilize reliable processes of fact-gathering, analysis, and response to risk; and
- A fair and equitable response to team members, physicians, and contractors, including a No Retaliation policy when team members escalate risk concerns in good faith.

EMPLOYEES AND PHYSICIANS ARE EXPECTED TO:

- Fully utilize the resources made available by ORGANIZATION in the performance of their duties;

⁷ The CJCP review shall be performed and documented by the CJCP Executive Oversight Committee at regular intervals, at a minimum of once a quarter, with an annual evaluation of the effectiveness of the CJCP objectives and measures.

- 
- See, understand, report, and manage risk within the capacity of their job responsibilities;
 - Participate in ORGANIZATION fact-gathering and improvement processes when called upon;
 - Report to the appropriate level of leadership in a timely fashion when a significant risk is recognized, and harm may occur;
 - Escalate risk concerns to the appropriate leadership in good faith; and
 - Uphold responsibilities for their individual knowledge, skills, abilities, and other professional requirements.

ESCALATION POLICY

We expect that every team member and physician will face circumstances in the workplace where multiple values and competing priorities exist. When such circumstances occur, it is our expectation that individuals escalate their concerns in a timely manner, up to and including the highest-ranking authority available at the time, whether that authority is near the circumstance or not. Each department is responsible for establishing the processes and procedures supporting such escalation.

We pledge to support any team member and/or physician who escalates a concern in good faith, and we will be guided by the Collaborative Just Culture policy in support of those individuals.

PROCEDURE

The Triad Process and Threshold for Initiating a Review

The CJCP Triad Review Process helps ensure management actions involving employees are consistent with the Collaborative Just Culture policy and program. The Triad Review Process utilizes the CJCP Reliability Response Guide™ as an operational tool to apply CJCP principles reliably.

- The Triad convenes when a significant organizational risk is recognized and warrants further review. The Triad meets in person or via other media, such as a phone bridge or video conference. The threshold for Triad meetings may involve risk and events involving significant changes to socio-technical systems where system improvements and/or team member actions may be warranted, and the operational manager and/or the RMT has not reached a consensus. Examples of Triad reviews include risk or events where:
 - Potential disciplinary action with a team member or physician is considered, up to and including termination of employment and/or restrictions of privileges, or
 - A manager/supervisor has not held an individual accountable to complete a behavioral or performance remediation plan.
 - A significant change to an operating system, process, or device is proposed, and the RMT cannot reach consensus on a strategy, such as:
 - System changes modifying operational processes or having multi-divisional impact.

Triad Review Team Composition, Roles, and Responsibilities

The Triad review process is a partnership that depends on the balanced participation of diverse participants with independent perspectives and areas of expertise. Only qualified individuals who have been trained to proficiency in the Sequence of Reliability and the use of the Reliability Response Guide will participate in the review process

(Triad Team members need not be members of the Reliability Management Team). The Triad Review Team composition – along with roles and responsibilities – are listed below:

- **Facilitator – Reliability Management Team Chair or Member**
 - Facilitates and guides the Triad Review Team meeting process.
 - Procures resources, including subject matter experts, witnesses, and other contributors to participate as required.
 - Documents and reports all findings and recommendations, as needed, to the appropriate organizational executive and/or leadership team.

A. Management Representative

Provides the management viewpoint responsible for managing the systems and human performance of the work environment(s) being reviewed. When multiple departments are involved, the management representative may collaborate with multiple other operational individuals, but only one management viewpoint may be documented in the final determination of unanimous consensus of agreement on each of the findings and recommendations.

B. Human Resources (HR) Representative

Provides the HR perspective to ensure workplace fairness and to monitor culture and team member relations throughout the review process. The People and Talent team member may collaborate with multiple other HR individuals, but only one HR viewpoint may be documented in the final determination of unanimous consensus of agreement on each of the findings and recommendations.

C. Role-Qualified RMT Member (e.g., Safety/Quality/Risk Representative)

Provides a system-based perspective, independent from the views of the operations and HR members. It is recognized that Safety, Quality, and Risk are often represented by different people – the Triad must choose a person to represent these views. The Triad Team member may collaborate with multiple other Safety/Quality/Risk professionals, but only one member viewpoint is documented in the final determination of unanimous consensus of agreement on each of the findings and recommendations.

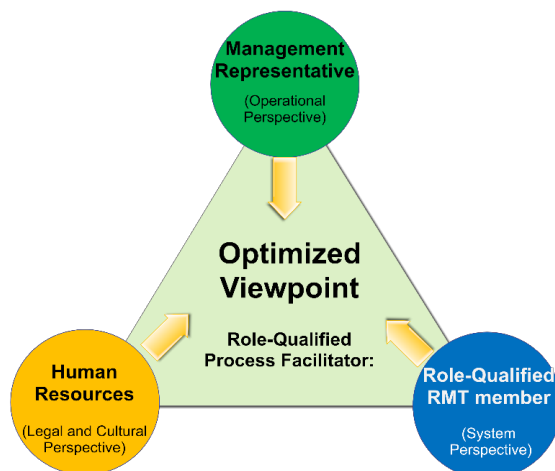


Figure 5



Training-to-Proficiency Qualifications for Triad Team Members

Collaborative Just Culture Program training consists of a series of online computer-based learning, live videoconferencing and/or instructor led classroom training. The {ORGANIZATION department and individual, listed by position} will be the record-keepers for the CJCP training and qualification process. Although not required to be a member of the Reliability Management Team, each Triad Team member shall be trained to proficiency commensurate with Reliability Management Team member qualifications.

Prior to taking the instructor-led courses, the corresponding online course must be successfully completed.

- Note: Just Culture Triad Review Team members will be required to maintain annual proficiency by participating in at least two (2) Triads per calendar year and/or participate in two 1-hour Collaborative Just Culture education online or videoconferencing sessions.

Avoiding Conflicts-of-Interest and Biases

Triad members must avoid any conflicts-of-interest in a Triad Review (e.g., personal relationships extending beyond the professional; financial or service referral ties). To the extent possible, the Triad must also recognize, guard against, and manage a range of individual and organizational biases, including, but not limited to: racial, gender, ethnic, or faith-based biases; outcome and hindsight bias; professional bias; manager's/team member's bias; normalcy bias; confirmation bias; and fundamental attribution bias.

Use of Internal and External Experts

The Triad is encouraged to use internal and/or external subject matter experts as needed. These subject matter experts, however, are not counted as representatives on the Triad and their viewpoints are not binding with respect to the Triad requirement for unanimous consensus.

Achieving a Unanimous Consensus

- The success of the Triad review process depends on the team achieving unanimous consensus of agreement on all findings and recommendations resulting from the review. The Reliability Response Guide will yield reliable results when applied consistently through collaboration. An optimized viewpoint is achieved when members of the Team bring differing perspectives and expertise into alignment, each adding value to seeing, understanding, and managing organizational risk.

Triad Team Findings and Recommendations

- The {ORGANIZATION department and individual, listed by position} shall maintain documentation of all Triad Review team findings and recommendations, including the organizational response and accomplishment(s).
- The Triad Review Team must be careful to acknowledge where clinical and/or technical expertise may be required beyond the experience of the Triad Team, particularly in cases involving system design risk. In such cases, Triad Review Team findings are preferred over recommendations. The difference being that the Triad Review Team may legitimately assess risk and produce a related finding, without exceeding their clinical and/or technical knowledge and expertise. This has the advantage of permitting the operational and domain experts to assess and develop solutions for managing risk, with the goal of producing optimal solutions.



Triad Review Escalation Process

In the event a Triad Review Team fails to reach a unanimous consensus of agreement on all findings and recommendations, the Triad facilitator shall report the non-agreement to the Executive Vice President / Chief Medical Officer or his/her designee for escalated review and resolution (The designee must be trained in the Sequence of Reliability methods).

{ORGANIZATION department and individual, listed by position} or designee may designate an additional Executive Triad Review Team to review the non-consensus items or may work collaboratively with the senior executives of HR and the operational departments involved to achieve departmental unanimous consensus of agreement. In the event the departmental unanimous consensus of agreement is still not achieved, the {ORGANIZATION department and individual, listed by position} will be notified to provide consultation with the Chief Executive Officer in making the final determination on the findings and recommendations.

DEFINITIONS

Performance Management – an organizational approach to managing human performance, including managing:

- Knowledge, Skills, Abilities, and Proficiencies (KSAPs);
- System influences (training, environment, policies and procedures, equipment, etc.);
- Personal influences (health issues, past experiences, perceptions of risk, etc.);
- Cultural influences;
- Environmental influences;
- Perceptions of risk; and
- Competing priorities.

Note: Performance management is non-disciplinary and must be applied and reviewed in sequence before behavior management. Performance improvement (or remediation) plans are used to improve performance to meet organizational tolerances. If an individual fails to successfully complete a performance improvement plan, reassignment or termination of employment may result. These actions are documented as risk management decisions, not as a disciplinary discharge.

Behavior – actions or inactions. Behaviors are grouped into two main categories: 1) choices, and 2) human errors.

Behavioral Choice – usually a conscious choice, and often associated with an expectation to follow a policy, rule, procedure, or other organizational expectation.

Behavior Management – an organizational approach to managing choices and/or human errors after Performance Shaping factors have been examined and Performance Management applied, if applicable. There are eight human behaviors identified in the Reliability Response Guide:⁸

- **Choice Where the Organization's Behavioral Expectations Were Not Made Clear**

⁸ The terms used in the Reliability Response Guide™ as behavioral review standards are for ORGANIZATION's internal use only to determine organizational response to identified behaviors. These identifying terms bear no relation to and shall not be construed to constitute admission to same or similar legal standards.

- **Choice Where the Expectations** (including a rule, policy, or procedure) **Were Impossible to Meet under the Circumstances** (e.g., weather, physical limitation, or other extenuating event or condition).
- **Human Error⁹** – an inadvertent action – a cognitive or physical slip or lapse: doing other than what was intended (e.g., a slip), or forgetting or not doing something that was intended (e.g., a lapse).
- **Justifiable Choice** – A choice that the organization deems justifiable, even if the action deviates from a rule, policy, procedure, or other expectation.
- **At-Risk Behavior** – A behavior choice that increases risk where risk is not recognized or is mistakenly believed to be justified.
- **Reckless Behavior** – A conscious disregard of substantial and unjustifiable risk of causing harm.
- **Knowingly Causing Unjustifiable Risk or Harm** – a choice where unjustifiable harm is practically certain to occur.
- **Purposely Causing Unjustifiable Risk or Harm** – a choice where the purpose of the behavior is to cause unjustifiable harm.

Disciplinary Action – an organizational response to a team member, physician, or contractor used as a behavioral deterrent. Note: Disciplinary is not used in Performance Management, which is remedial. Examples of disciplinary action include deterrents such as verbal warnings or a letter in a personnel file and actions having an economic impact on the individuals such as suspension without pay and/or termination of employment.

Collaborative Risk Review – a participatory, majority consensus-based process involving individuals from multiple departments and work groups for the purpose of seeing, understanding, and managing risk.

Proficiency – Competency and/or expertise sustained over time. A proficiency evaluation is a time-based, independent assessment of competency, usually designated by a qualification.

Reliability Management Team – A cross-departmental ORGANIZATION team comprised of leaders and team members who are trained in CJCP and Collaborative High Reliability (CHRO) and guide the organization's efforts to external qualification and certification.

Triad Team Member – An operational division leader, People and Talent (HR) representative, or Safety/Quality Risk department professional who is trained to CJCP proficiency and qualification. In addition, they are trained and authorized to perform Triads. The representatives are utilized as a resource to guide and assist operational departmental leaders in sustaining reliability. Triad team members are accountable for Triad reviews and for producing findings and recommendations, when applicable.

Findings and Recommendations – The output of Triad Team reviews are documented findings and recommendations, to be monitored and measured as an indicator of CJC program effectiveness.

⁹ Mistakes are sometimes used to describe either: 1) an inadvertent human error, or 2) a poor behavioral choice. This term is NOT recommended for use in the CJCP because it can lead to confusion and improper organizational response.



Cross-Referenced Policies:

Where discrepancies may exist regarding disciplinary action in any ORGANIZATION policy or guidance material, this CJCP supersedes the others. The following policies may overlap with the guidance regarding disciplinary action contained in this CJCP policy:

- Collaborative Risk Review Policy and Manual;
- Performance and Behavior Management (including Progressive Discipline, Performance Improvement Plan Policy, and Performance Appraisal);
- Code-of-Conduct;
- Attendance;
- Conflict Resolution and Grievance; and
- Recruitment and Employment



APPENDIX B –

Model Reliability Management Team™ Charter



PURPOSE

The Reliability Management Team (RMT) is a cross-departmental and cross-functional team whose purpose is to help the organization see, understand, and manage risks using the Sequence of Reliability. The RMT accomplishes this by:

1. Guiding the development and sustainment of Collaborative Just Culture Program (CJCP) qualification.
2. Once CJCP qualification is achieved, the RMT will work toward Collaborative High Reliability Organization (CHRO) certification which requires the development of a Reliability Management System (RMS).

GOVERNING BODY

The governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the organization), medical staff, and administrative officials are responsible and accountable for ensuring that the organization selects, trains to proficiency, and maintains an ongoing Reliability Management Team (RMT).

RMT LEADER(S)/MENTOR(S)

The function of an RMT Leader/Mentor is to guide, coordinate, and oversee all RMT responsibilities, including the selection of RMT members and individual SME role-qualifications necessary for reliable team administration and CJCP qualification. There may be more than one individual serving this role, but the functions must be aligned and integrated. Leaders/Mentors may share RMT leadership responsibilities as co-leaders. Examples include:

- Chief Reliability (or Quality, Safety, or Risk) Officer;
- Chief Human Resources Officer;
- Operational Executives;
- Chief Pilot;
- Chief Medical Officer;
- Chief Nursing Officer; and
- Other leaders.

RMT COMPOSITION

The RMT shall be comprised of members from various departments, roles, and responsibilities within the organization. RMT members shall be trained to proficiency in CHRO methods to see, understand, and manage risk. They will serve as internal subject matter experts and change agents to lead the organization in the journey toward Collaborative High Reliability. RMT members shall include representatives from:

- Human Resources;
- Safety;
- Quality;

- Performance Improvement;
- Risk Management;
- Clinical Departments – Medical Staff and Nursing Staff;
- Flight Departments;
- Maintenance or Facilities Departments;
- Non-Clinical Support Departments – Education, Information Technology, Environmental, Facilities, Other Departments; and
- Front-line Staff.

ROLE-QUALIFIED SPECIALISTS

At a minimum, the RMT shall include the individuals who are trained-to-proficiency and qualified in the following roles:

- **Leader/Mentor:** Organizes, manages, and assumes responsibility for CJCP qualification and the RMT's performance; mentors leadership, managers, and supervisors;
- **Fact-Gatherer:** Gathers facts and conducts analysis;
- **Process Facilitator:** Facilitates Collaborative Risk Reviews and Triad Reviews;
- **Instructor¹⁰:** Provides training on CJCP and CHRO standards; and
- **Consultant/Examiner¹¹:** Serves as an advisor to guide the organization to achieve CJCP qualification, including conducting examinations for the above role-qualifications, provided another qualified Instructor or Consultant conducted the training to ensure impartiality and objectivity in the evaluation process.

RMT MEETING SCHEDULE

- The RMT shall meet no less frequently than one per month face-to-face or by video platform.

RMT RESPONSIBILITIES

- **Apply the Sequence of Reliability to guide the organization in seeing, understanding, and managing risks:**
 - Evaluating, tracking, and trending all identified risks and adverse events;
 - Initiating, developing, implementing, and facilitating a Collaborative Risk Review process; as a consistent method to achieve the collaborative management of risk;

¹⁰ May be outsourced to external consultant organization.

¹¹ May be outsourced to external consultant organization.

- Initiating, developing, implementing, and facilitating a Triad Review process as a consistent method to respond to employees and contractors (including physicians) involved in identified risks and adverse events; and
 - Ensuring all employees and contractors are trained-to-currency in their organizational roles at the appropriate level in accordance with the CJCP policy.
- **Educate and support leaders, managers, and supervisors** in CHRO concepts and methods.
- **CHRO training:**
 - For each RMT member shall be documented including name, position, RMT role and responsibilities, completion of online and classroom training, and validation of continuing proficiency with CHRO tools (Frequency of validation of continuing proficiency shall be determined by the organization based on the role of the RMT member);
 - Shall be included for newly hired or promoted Managers;
 - Shall be provided during on-boarding new employees; and
 - Has a process for measuring competence and proficiency.
- **Align organizational policies and systems** including (at minimum):
 - Human Resources;
 - Safety;
 - Quality Improvement;
 - Performance Improvement;
 - Risk Management;
 - Code-of-Conduct;
 - Attendance;
 - Conflict Resolution and Grievance; and
 - Recruitment and Employment.
- **Develop sustainment and succession plans to include:**
 - Ensure CJCP sustainment (i.e., currency) training is conducted and documented; and
 - Each SME role-qualified Leader/Mentor shall develop and document a succession plan.

EXPECTED RMT ACCOMPLISHMENTS

- **Develop and implement a Reliability Management System (RMS)** for seeing, understanding, and managing organizational risks. The RMS shall measure and monitor the following organizational attributes of high reliability (as a minimum):

- 
- Safety (patients/customers, visitors, and staff);
 - Customer service (e.g. healthcare organizations include compassionate care, airlines include on-time performance, Emergency Medical Services include response time, etc.);
 - Privacy;
 - Equity (patient care, access, treatment of staff);
 - Financial Stewardship; and
 - Operational Integrity.
- **RMT Key Results** include:
 - Organizational Attributes are defined and published in a CJCP policy;
 - Human Resources performance and behavior management policies are aligned with the Sequence of Reliability;
 - The Collaborative Risk Review process is documented and implemented;
 - The Triad Review process is documented and implemented;
 - RMT members serve as organization subject matter experts and internal resources for CHRO.
 - The Collaborative Just Culture Program (CJCP) passes audit qualification; and
 - The organization achieves Collaborative High Reliability Organization (CHRO) certification.



APPENDIX C – TERMS AND DEFINITIONS

TERM	DEFINITION	ADDITIONAL NOTES
Acronyms (used in this document)	ASAP – Aviation Safety Action Program CHRO – Collaborative High Reliability Organization CRR – Collaborative Risk Review CJCP – Collaborative Just Culture Program CRM – Crew Resource Management FMEA – Failure Mode & Effects Analysis FTA – Fault Tree Analysis KSAPs – Knowledge, skills, abilities, and proficiencies QMS – Quality Management System RCA – Root Cause Analysis RMS – Reliability Management System RMT – Reliability Management Team SMS – Safety Management System STPRA – Socio-technical probabilistic risk analysis	
Align & Integrate	Align: Ensuring processes, policies, programs, systems, and integrated systems are consistent with CHRO taxonomy and methods and do not directly or indirectly oppose each other. Integrate: The act of combining or coordinating aligned processes, policies, programs, and systems into an integrated system.	Integrated systems form a cohesive whole, incorporating CHRO taxonomy and methods to ensure reliable results. By applying the Sequence of Reliability, CHRO organizations align and integrate all work performed under a common strategy and set of standards. A Reliability Management System provides a dashboard to assess ongoing reliability.
At-Risk Choice	A behavioral choice that increases risk where risk is not recognized or is mistakenly believed to be justified.	The action is chosen without the intention to cause unjustifiable harm.

TERM	DEFINITION	ADDITIONAL NOTES
Attributes of Collaborative High Reliability Organizations	• Safety • Customer Service • Privacy • Quality • Financial Responsibility • Operational Integrity • Equity	While not all-inclusive, these attributes are the minimum necessary to demonstrate reliability under Collaborative Just Culture program qualification and Collaborative High Reliability Organization certification standards.
Attributes of Reliable Systems	Reliable systems are: 1. Effective Successful in producing a desired or intended result when things go right, and 2. Resilient Able to withstand or recover quickly from difficult conditions when things go wrong	System Design Strategies include: • Barriers – Obstacles put in place to prevent failures • Redundancies – Parallel components – Backups • Recoveries – Ways to correct when things go wrong
Behavior	Actions or inactions.	Behaviors are grouped into two main categories: • Choices • Human errors
Behavioral Choice	A human choice – usually a conscious choice, and often associated with an expectation to follow a policy, rule, procedure, or other organizational expectation.	In CHRO organizations, Performance shaping factors are always examined before applying Behavior Management. Performance shaping factors –both systems and personal – often influence behavioral choices. Behavioral choices that increase risk often respond to coaching that is intended to <i>increase risk intelligence</i>. If behaviors do not respond to coaching, action in the form of discipline may be taken. After time and repetition, choices can become automatic, where little thought is given to not following a policy, rule, procedure, or other guideline.



TERM	DEFINITION	ADDITIONAL NOTES
Behavior Management	An organizational approach to managing choices and/or human errors after Performance Shaping factors have been examined and Performance Management applied, if applicable. (See Human Behavior definitions below)	There are multiple human behaviors identified in the CHRO Reliability Response Guide™. Behavior management may be required when an individual's choices and/or human errors increase risk beyond organizational tolerance. A balanced behavior management strategy includes the following: • Organizational expectations have been clearly explained; • Individual support measures, including coaching, validation, and/or recognitions; • Formal, documented counseling; and • Formal, documented discipline resulting from a Triad Review – for deterrent effect – including reductions in compensation, work assignments, benefits, and/or privileges.
Causal Factors	Usually divided into either Direct cause ("A" caused "B") or probabilistic cause ("A" increased the probability of "B"). It may not be possible to retrospectively determine a percentage of probability attributing to cause.	The term contributing factor is preferred. The term <i>causal factor</i> often biases the observer to focus on a singular contributor, such as <i>root cause</i> or <i>probable cause</i>.
Collaborative High Reliability Organization (CHRO)	An organization committed to achieving sustained high performance over time using the Sequence of Reliability: 1. See and Understand Risk 2. Manage Reliability in this order: a. System (effective and resilient) b. Human (performance and behavior management) c. Organization (document, monitor, measure, align, and integrate)	Collaborative High Reliability organizations are independently audited to currency and proficiency using Qualification and Certification standards. • Collaborative Just Culture Program Qualification • Collaborative High Reliability Organization Certification (Tiers 1 through Tier 3)

TERM	DEFINITION	ADDITIONAL NOTES
Collaborative Risk Review	A Collaborative Risk Review is a participatory process involving multiple departments and work groups for the purpose of seeing, understanding, and managing risk.	A Collaborative Risk Review requires a fact-gathering process, which is necessary to accomplish before the review. A CRR process should be documented, aligned, and integrated with other processes and programs, including Root Cause Analyses (RCAs), Triad Review processes, and Collaborative Just Culture programs. In CHRO organizations, the process is part of a Reliability Management System.
Competency	The quality or state of being able or suitable for a particular task; the quality or state of being competent for a particular task.	Compare with the definitions of <i>proficiency</i> and <i>currency</i> .
Collaborative Just Culture® Program (CJCP)	A program to help achieve high reliability through workplace justice and collaboration.	Collaborative Just Culture® Program (CJCP), follows the Sequence of Reliability in managing organizational risk, using the Reliability Response Guide to provide a balanced approach to seeing, understanding, and managing systems, human performance, human behavior, and organizational response. • Evidence-based standards • Documented, monitored, and measured • The first just culture program of its kind to be independently audited by a third-party • A CJCP tool requires a Triad process to support its reliable application.
Contributing Factors	Factors that increase the probability that an event or undesired outcome will occur. Typically stratified into three contributing groups: • System factors; • Human performance factors (Knowledge, skills, abilities, & proficiencies, system, personal, environmental, and cultural influences, etc.); and • Human behavioral factors (choices and errors).	Currently, the most effective method for stratifying and managing contributors to risk. Contributing factors assist the organization in proactively seeing, understanding, and managing risk rather than focusing on singular (or a limited number of) contributors to past events. Contributing factors are often probabilistic causes ("A" was not necessarily a direct cause but increased the probability of "B").

TERM	DEFINITION	ADDITIONAL NOTES
Currency	The documented quality or state of being competent and up to date for a particular task.	Currency requires continued competency over a specified time-period, which may be accomplished by continued use, refresher training, or other documentation. Compare with definitions of competency and proficiency.
Crew Resource Management (CRM)	Crew Resource Management is a set of training techniques and procedures to manage risk involving teams in high consequence industries.	CRM is often presented as a collection of communication techniques allowing teams to communicate effectively regardless of time pressure or hierarchy. CRM can assist team members in gaining an understanding of other team members' risk intelligence and risk tolerances, promoting strategies to improve team performance and safety.
Disciplinary Action	Organizational response to an employee or contractor used as a behavioral deterrent. Note: DISCIPLINARY ACTION is not used in Performance Management, which is remedial.	The term CORRECTIVE ACTION is used in some industries to mean disciplinary action; other industries use the term to mean non-disciplinary remedial action. To avoid confusion, the CHRO Requirements document uses the term DISCIPLINARY ACTION to describe action meant to be a behavioral deterrent. Examples include deterrent actions, such as verbal warnings and a letter in a personnel file, and actions having an economic impact on the individuals, such as suspension without pay and/or termination of employment.
Document, Monitor, & Measure	Document: The act of committing a process, policy, program, system, or integrated system to written record. Documentation shall be widely and easily accessible to those individuals and teams who rely on its guidance, and to those serving oversight roles and responsibilities. Monitor: The act of reviewing the <i>effectiveness</i> and <i>resilience</i> of a process, policy, program, system, or integrated system. Measure: The act of assigning a score or value to the <i>effectiveness</i> and <i>resilience</i> of a process, policy, program, system, or integrated system.	The terms are often associated with principles of quality management. CHRO builds on these principles and expands them to require <i>alignment</i> and <i>integration</i> to produce sustainable organizational performance.

TERM	DEFINITION	ADDITIONAL NOTES
Effective (System)	Successful in producing a desired or intended result when things go right.	Produces reliable results while managing risk if the components are operating as designed, including hardware, software, and human operators.
Event Reporting System	A system of reporting events that cross a threshold as reportable events.	Event reports often suggest a threshold near harm or regulatory/procedural compliance, which, in some cases, creates an Outcome Bias. In CHRO, the term <i>Risk Reporting System</i> is preferred.
Fact-Gatherer (Role Qualification)	A Reliability Management Team member or organizational specialist trained to proficiency in gathering facts and conducting analysis.	
Failure Modes and Effects Analysis (FMEA)	Failure Mode and Effects Analysis. A restricted process typically used to determine where a system will fail.	FMEA is often intended to be a proactive method of system risk assessment rather than as an event review technique. It does not typically account for the Inherent Failure Rates of humans (see below). There are multiple methods for conducting FMEAs. Lean processes associated with FMEAs may lack the probability of human failure factored into the analysis.
Fault Tree Analysis (FTA)	FTA is an event-oriented analysis technique, allowing for the consideration of hardware failures and other undesirable events, such as software failures, human errors and behavioral choices, operation and maintenance errors, and environmental influences.	FTA is based on a simple set of rules and logic symbols (such as AND gates, OR gates, and others) from probability theory and Boolean algebra. It consists of generating a logic model that allows for both qualitative and quantitative evaluation of reliability or availability.
Inherent Rate of Failure	The calculated failure rate associated with a given system (as a whole), a system component, an individual task, or a group performance. Inherent failure rates are never zero and can be estimated using advanced probability modeling, including socio-technical probabilistic risk assessments (STPRA) and other resources.	Failure rates must be determined from both the system and the human perspective. Human failures are either Performance-related (generally cognitive aspects) or related to Behaviors (inadvertent errors and/or conscious choices).
Higher Culpable Behaviors	Knowingly Causing Unjustifiable Risk or Harm – A choice where unjustifiable harm is practically certain to occur. Purpose to Cause Unjustifiable Risk or Harm – A choice where the purpose of the behavior is to cause unjustifiable harm.	

TERM	DEFINITION	ADDITIONAL NOTES
Huddles	A process that includes a gathering of individuals intended as a handover (i.e., transfer of) status updates and operational priorities.	Huddles can be opportunities for collaborative, proactive risk assessment and sharing risk intelligence related to a given situation or work area. Huddles usually cover a defined period (e.g., before an 8-, 12-, or 24-hour operational period or for a specific team procedure). Huddles have demonstrated effectiveness at every level. Executive huddles, unit-level huddles, and even individual handovers can benefit from the process.
Human Error	An inadvertent action – a cognitive or physical slip or lapse: • doing other than what was intended (e.g., a slip), or • forgetting or not doing something that was intended (e.g., a lapse).	By definition, human error is not a conscious choice.
Human Resources Management System	A collection of human resource (HR) processes and programs to ensure the effective management of employees and contractors, business processes, and data.	Human resources software is used by businesses to combine necessary HR functions, such as storing employee data, managing payroll, recruitment, benefits administration, time and attendance, employee performance management, and tracking competency, currency, and/or proficiency and training records.
CJCP/CHRO Instructor (Role-Qualification)	An RMT or organizational specialist trained to proficiency to train the Collaborative Just Culture and Collaborative High Reliability standards and taxonomy.	

TERM	DEFINITION	ADDITIONAL NOTES
Integrated System	In CHRO, an integrated system performs a function, comprising aligned and integrated components, producing measurable results. An integrated system's components include systems, programs, and processes. An Integrated System description includes: • Purpose of the system • System components • How they align and integrate • The results expected from the system • How the results are monitored and measured	Key words include "align and integrated." In CHRO, a system must be more than a collection of elements and/or activities. The components must align and integrate to perform a measurable function. Align = The component description must refer to the system, and no part of the component shall conflict with the purpose and function of the system (e.g., program policies and processes must not be in conflict). Integrate = All components must function in relation to the other components to support the purpose and function of the system. Integrated components will describe the inter-relatedness and overlap with other system components. (e.g., Risk, Quality, Safety, Performance Improvement, and Human Resources programs that describe fact-gathering, analyses, and organizational response to risk and events.)
Just Culture	Traditional definition: Just Culture has been used as an aspirational activity to categorize and respond to human behavior, intended to provide both fairness and accountability. Traditional Just Culture activities are often seen as an algorithmic approach to evaluating a rule or policy violation. It has commonly been used as an HR tool for supervisors in determining how to respond to a person (console, coach, or punish.) after assessing duty and breach.	A Collaborative Just Culture® Program (CJCP), by comparison, is a program to help achieve high reliability through workplace justice and collaboration. A CJCP follows the Sequence of Reliability in managing organizational risk, using the Reliability Response Guide™ to provide a balanced approach to seeing, understanding, and managing systems, human performance, human behavior, and organizational response. • Evidence-based standards; • Documented, monitored, and measured; • The first just culture program of its kind to be independently audited by a third-party; and • A CJCP tool requires a Triad process to support its reliable application.
Leader/Mentor (Role-Qualification)	An RMT or organizational specialist trained to proficiency in the leadership skills necessary to organize, manage, and assume responsibility for CJC program qualification and the RMT's performance; and to mentor leadership, managers, and supervisors	

TERM	DEFINITION	ADDITIONAL NOTES
Mistake	Mistake is often used to describe either: • An inadvertent <i>human error</i>, or • A poor behavioral choice.	The term <i>mistake</i> often masks the true contributing factors and can create bias. For example, the phrase "Everyone makes mistakes" is a common term. A more accurate observation is: "Everyone makes inadvertent errors, and everyone occasionally makes poor behavioral choices." Clarifying whether a mistake is a <i>human error</i> or a <i>behavioral choice</i> allows appropriate accountability and risk mitigation to take place.
Organizational Response Tool	A tool used as an organizational guide to respond to risk, events, and/or reports. The purpose of the tool is to help ensure a reliable response.	In a Collaborative Just Culture® program, a Triad Review process has been demonstrated to ensure reliable use of organizational response tools.
Outcome Bias	A human and/or organizational bias where the severity of the outcome determines the level of response, disregarding the risk of future outcomes.	There are two types of Outcome Bias: • No adverse outcome – often resulting in "turning a blind eye" to the system and human contributors to the risk. • Adverse Outcome – at times resulting in an overreaction, where the response may be disproportionate to the system or human contributors. Both Outcome Bias responses may contribute to perceptions that people are not treated equitably.
Performance Management	An organizational approach to managing human performance, including: • Knowledge, Skills, & Abilities (KSAs) • System influences (training, environment, policies and procedures, equipment, etc.) • Personal influences (health issues; past experiences; biases; stress, distraction, fatigue from outside the workplace, etc.) • Cultural influences • Perceptions of risk • Competing priorities	Performance management shall be non-disciplinary and must be applied and reviewed in sequence before behavior management. Performance improvement (or remediation) plans are used to improve performance to meet organizational tolerances. If an individual fails to successfully complete a performance improvement plan, reassignment or termination of employment may result following a Triad Review. These actions are documented as risk management decision, not as a disciplinary discharge.

TERM	DEFINITION	ADDITIONAL NOTES
Performance Shaping Factors	Factors influencing human behavior, including, but not limited to: • Knowledge, skills, abilities, and proficiencies; • System influences (e.g., training, environment, policies, processes, procedures, equipment; organizationally based distractions, inequities, stress, fatigue, etc.); • Personal influences (e.g., health issues, past experiences, perceptions of risk; personal-based distractions, stress, fatigue, and biases, etc.); and • Other factors: – Cultural Influences – Perceptions of risk – Competing priorities – Personal disadvantages/advantages	Performance shaping factors should be examined before assessing human behavior to better: • See, understand, and manage the risk(s), and • Ensure fair and consistent response to the individual(s).
Power Gradient	The perceived power difference between two or more people. It may be associated with formal hierarchy, technical expertise, or experience.	Power gradients are sometimes not recognized by those who are perceived to be in power. Managing power gradients is most effective when the person who has less power is trained to engage with those in power.
Process Facilitator (Role-Qualification)	An RMT or organizational specialist trained to proficiency in the leadership skills necessary to facilitate Collaborative Risk Reviews and Triad Reviews.	
Proficiency	Competency and/or expertise sustained over time. A proficiency evaluation is a time-based, independent assessment of competency and/or expertise, usually designated by a qualification.	Proficiency is sustained competency and/or expertise often demonstrated under varied conditions over time. Compare with the definitions of competency and currency, which are demonstrated by meeting minimum standards required for a task or role typically defined for routine conditions.



TERM	DEFINITION	ADDITIONAL NOTES
Quality Management System	A quality management system (QMS) is a collection of business processes and programs focused on consistently meeting customer requirements and enhancing satisfaction. A QMS helps coordinate and direct an organization's activities to meet customer and regulatory requirements and improve its effectiveness and efficiency on a continuous basis.	QMS is a general, process-driven approach to organizational improvement. ISO 9001 is one demonstrated approach to certifying QMS. CHRO is a more prescriptive set of steps needed to achieve Qualification and Certification. CHRO supports multiple defining organizational attributes that may be industry specific.
Reliability Management System (RMS)	A Reliability Management System is a collection of documented, aligned, and integrated processes, programs, and systems providing a structure for seeing, understanding, and managing organizational risk.	By integrating and harmonizing processes, programs, and systems, each element of the RMS is documented, monitored, and measured, providing an auditable standard of evaluation for sustainable performance. Examples include, but are not limited to: • Reliability Management Team(s); • Triad Process; • Quality Management Program; • Safety Management Program; • Risk Management Program; • Human Resource Management Program; • Performance Improvement Program; • Compliance Program; • Operational activities; • Information Technology and other infrastructure systems; and • Education and training program.

TERM	DEFINITION	ADDITIONAL NOTES
Reliability Management Team	A Reliability Management Team (RMT) is a cross-departmental team of individuals guiding an organization to Collaborative High Reliability Certification, serving as CHRO SMEs. At a minimum, an RMT includes the following representation: • Human Resources; • Quality/Safety/Risk; • Operations; • Frontline staff and/or labor; • Infrastructure (e.g., facilities, IT, education, etc.); and • Other key organizational departments.	Selected RMT members are trained to individual qualifications, valid for no longer than two years. Role-qualification specialist include: • Leader/Mentor; • Fact-Gatherer; • Process Facilitator; • Instructor; • Consultant/Examiner; and • Auditor.
Risk	A condition, object, or other threat involving the probability of danger or harm. Risk is often associated with possible adverse outcomes – crashes, patient harm, customer impact, or other harmful events.	Organizational risk is directly associated with CHRO defining organizational attributes. Personal values, risk perception, risk intelligence, and risk tolerance, influence organizational risk.
Risk Intelligence	Individual risk perception and knowledge of probabilities associated with an adverse outcome. An ability to determine whether something will occur, usually based on experience, past practice, and repetition.	Situational Awareness is often directly associated with Risk Intelligence.
Risk Management Program	An organizational approach to assess, develop, implement, and monitor risk management processes with the goal of minimizing exposure.	A healthcare organization has multiple Risk Management priorities, such as finance, safety, and patient care. <i>A Risk Management System</i> would align these programs into a cohesive system using the same methods, tools, and processes.
Risk Tolerance	A level of risk acceptance applying to individuals, groups, and organizations.	Individual and group risk tolerance may vary widely. • CHRO organizations communicate risk tolerance clearly through actions, policy, and other guidance.

TERM	DEFINITION	ADDITIONAL NOTES
Risk Register	A ranking of organizational risks used to determine resource allocations based on risk intelligence and risk tolerance.	Risk registers may represent threats to multiple defining organizational attributes (e.g., safety, finances, privacy, customer service, quality, and/or equity). Risk registers are dynamic, representing changing risks. They may be categorized according to multiple dimensions, including: • Frequency or likelihood; • Severity; and • Duration.
Risk Reporting System	A system of reporting risks independent of outcome, based on severity, likelihood, and duration.	Risks may be reported according to a taxonomy, if desired. In the CHRO model, risks are categorized according to the Sequence of Reliability.
Role-Qualified Specialist (see below)	RMT individuals (and other individuals within the organization) trained-to-proficiency as CJCP subject matter experts.	CJC/CHRO Role-Qualified specialists include: • Leader/Mentor; • Fact-Gatherer; • Process Facilitator; • Instructor; • Consultant/Examiner; and • Auditor.
• Role-Qualified Leader/Mentor	An individual who has demonstrated proficient leadership skills necessary to organize, manage, and assume responsibility for CJC program qualification and the RMT's performance; and to mentor leadership, managers, and supervisors.	Role-Qualified Leader/Mentors are designated as internal SMEs by the organization seeking CJCP qualification and the organization is responsible for documenting role qualification for purposes of the CJCP qualification audit.
• Role-Qualified Fact-Gatherer	An individual who has demonstrated proficiency to gather facts and conduct analysis.	Role-Qualified Fact-Gatherers are designated as internal SMEs by the organization seeking CJCP qualification and the organization is responsible for documenting role qualification for purposes of the CJCP qualification audit.
• Role-Qualified Process Facilitator	An individual who has demonstrated proficiency to facilitate Collaborative Risk Reviews and Triad Reviews.	Role-Qualified Process Facilitators are designated as internal SMEs by the organization seeking CJCP qualification and the organization is responsible for documenting role qualification for purposes of the CJCP qualification audit.

TERM	DEFINITION	ADDITIONAL NOTES
Role-Qualified Instructor	An individual who has demonstrated proficiency to train the Collaborative Just Culture and Collaborative High Reliability standards and taxonomy.	Role-Qualified Instructors may be outsourced by the organization seeking CJCP qualification. The licensed affiliate is responsible for maintaining documented currency and proficiency records authorized by SG Collaborative Solutions in the performance of these role-qualifications.
Role-Qualified Consultant / Examiner	An individual who has demonstrated proficiency in the knowledge, skills, and ability to perform all CJCP role-qualification functions and serve as an advisor to guide the organization to achieve Collaborative Just Culture program qualification, including conducting examinations for the individual role-qualifications, provided another qualified Instructor or Consultant conducted the training to ensure impartiality and objectivity in the evaluation process.	Role-qualified Consultant/Examiners may be outsourced by the organization seeking CJCP qualification. The licensed affiliate is responsible for maintaining documented currency and proficiency records authorized by SG Collaborative Solutions in the performance of these role-qualifications.
Role-Qualified Auditor	An individual who has demonstrated proficiency to audit organizations to the Collaborative Just Culture and Collaborative High Reliability standards.	A role-qualified auditor must work for a qualified, licensed auditing organization. The licensed affiliate is responsible for maintaining documented currency and proficiency records authorized by SG Collaborative Solutions in the performance of these role-qualifications.
Sequence of Reliability	A method to achieving sustained high performance over time: 1. See and Understand Risk 2. Then manage reliability in this order: a. System (effective and resilient); b. Human (performance and behavior management); and c. Organization (document, monitor, measure, align, and integrate).	The Collaborative High Reliability® model and taxonomy start with applying the socio-technical science in a specific order, known as The Sequence of Reliability™. This sequence provides the foundation by which CHRO produces and sustains organizational improvement.

TERM	DEFINITION	ADDITIONAL NOTES
Taxonomy	A system of classification.	The CHRO taxonomy of terms includes: • Activity – actions that are usually not documented (e.g., practices); • Process – a documented set of activities (e.g., procedures, checklists, methods, etc.); • Program – a documented alignment of related processes and/or other components; • System – a documented alignment of programs, processes, and/or other components; and • Integrated System – a documented coordination of aligned systems, programs, policies, processes, and/or other components.
Threat And Error Management	A taxonomy originating in commercial aviation used in line operations, reporting and analysis systems. Its original goal was to maintain safety margins by training pilots and flight crews to detect and respond to events that are likely to cause damage (threats) as well as mistakes that are most likely to be made (errors) during flight operations.	The Sequence of Reliability is a more advanced, evolved model that delineates risk; systems; human performance and behaviors; and organizational response.
Triad Review Process	A Triad Review is a process supporting a Collaborative Just Culture® program by ensuring a reliable organizational response to employees and contractors involved in identified risks and events. The Triad is comprised of a three-person committee representing: • An operational unit manager where the event occurred or the risk resides; • Human Resources; and • Safety, Quality, or Risk department; or labor association representative.	A key feature of a Triad Review process is the requirement for the team members to achieve unanimous consensus agreement on all findings and recommendations. In CHRO organizations, the members of the Triad Review teams may be a subset of the organization's Reliability Management Team. The members of the Triad shall be qualified, trained-to-proficiency, and their qualifications recorded.



TERM	DEFINITION	ADDITIONAL NOTES
Unanimous Consensus	Unanimous consensus refers to a situation where every member of a group agrees on a particular decision or opinion. Achieving unanimous consensus often indicates strong cohesion and shared understanding within the group, as everyone supports the same purpose or outcome.	In a Collaborative Just Culture program, Triad Reviews require unanimous consensus on all findings and recommendations to achieve optimized response; otherwise, escalation is required to a final organizational decision-maker or decision-making team. Triad reviews that do not achieve unanimous consensus may be examined by the external audit organization and form the basis for CJCP disqualification. When achieving unanimous consensus, it's important to recognize and guard against: • Power gradients – individuals who may exert undue influence over other Triad Team members; and • Group Think – where team member camaraderie suppresses independent viewpoint.
Unjustifiable Risk or Harm	Risk or harm deemed unreasonable as determined solely by the organization or authority standing in judgment, based on the circumstances surrounding the behavior.	Under behavioral review standards, determination of how a behavioral choice is categorized when unjustifiable risk or harm is incurred may take into consideration an individual's capacity to see and understand risk, as well as other performance shaping factors.



APPENDIX D – TERMS TO AVOID / TERMS TO USE



TERMS TO AVOID	RATIONALE	TERMS TO USE
Causal Factor	The term <i>causal factor</i> often biases the observer to focus on a singular contributor, such as <i>root cause</i> or <i>probable cause</i> .	The term CONTRIBUTING FACTOR is preferred.
Egregious	A non-specific term not used in CHRO because it tends to bias event reviewers with ambiguous meanings.	Use of this term is often not defined, although it often refers to a choice resulting in significant risk or harm. The term RECKLESS or one of the HIGHER CULPABLE BEHAVIORS is preferred.
Hazard	Like many terms, Hazard is ambiguous and can be interpreted in too many ways to be of value in risk analysis. For example, driving could be considered a "Hazard," as can be walking down the street, riding a bicycle, giving any medication, flying an aircraft - etc. "Hazard" is a personal description that is unhelpful as a "label" when developing high reliability strategies.	Use risk terminology and associate the value that is being threatened with the risk analysis. If using the term, carefully define the Organizational Risk Tolerance associated with the hazard. "Ace Manufacturing believes operating a lathe without eye protection presents a significant risk of eye injury, and therefore operating lathes without appropriate personal protective equipment (PPE) is deemed hazardous."
Intentional Act	The term <i>intentional act</i> is ambiguous and could mean intention toward either: - the act itself (often a violation of a rule, policy, or procedure), or - the consequence or potential harm. Intentional acts must be examined and categorized to determine how to best manage them.	The term CHOICE is preferred, with distinctions made categorizing it as: - Choice made where the organization's expectations were not clear, - Impossible to choose otherwise, - Justifiable, - At-risk, - Reckless, - Knowingly causing unjustifiable harm, or - Purpose to cause unjustifiable harm.
Investigation	Common in Law Enforcement. It tends to add an unnecessary enforcement tone to the analysis of risk.	Alternative phrases include: - Fact gathering - Review



TERMS TO AVOID	RATIONALE	TERMS TO USE
Latent Conditions	A broad, non-specific term that has been used to describe pre-existing conditions. The term tends to bias one toward thinking these are clearly identifiable conditions that can be "fixed."	A balanced approach to managing individual, team, and organizational risk. Specific terms should be used to define areas that need proactive attention - System Issues, Human Performance Factors, and Behaviors.
Mistake	See above. When the term <i>mistake</i> is used, it can cause confusion whether the behavioral contributor was an <i>inadvertent error</i> (where we would look for additional contributors to the error, such as system, personal, environmental, or cultural contributors), or whether the person simply made a choice that they regret afterward based on the consequences.	If the mistake was an inadvertent action (or inaction), use the term Human Error . If the mistake was a conscious action, use the term Behavioral Choice .
Negligent	A legal term not used in case review, socio-technical probabilistic risk analysis (STPRA), or Collaborative Risk Review (CRR). This is an "After Harm" term that does not help identify contributing factors to risk. Negligence can be associated with system failures, human performance failures, choices, and human error. Because it is a legal term with little value in identifying proactive steps to manage future risk, it is not used during CCR's or other CHRO analyses.	This legal term does not distinguish the CJCP definitions: • human error, • at-risk choice, and • reckless choice. In most instances, the terms above provide better clarity to guide organizational response. However, this term is often used by Risk Management as they determine steps to protect the organization from claims.
Preventable	The term is very general and cannot be directly associated with any proactive safety or quality measures that can be taken. By labeling things "preventable," the organization risks overlooking the primary contributors for the event or risk. In addition, this focuses on the <i>outcome</i> and not on the <i>contributors</i> . The term begs the question, which contributor was preventable, at what point during the operational sequence, and how so?	It is preferable to use specific contributor terminology. Rather than "Preventable Death or Event," state what the contributors were to the event: The following System Issues, Human Performance Factors, and Behavioral Choices contributed to the outcome." Or, if <i>not</i> preventable, "No known System, Human Performance, or Behavioral Choice factors led to the outcome. In future similar cases, the organization may improve reliability through the following measures: (State System, HPF, and BC suggestions).



TERMS TO AVOID	RATIONALE	TERMS TO USE
Risk Competence	This term assumes there is a standard level of competence in seeing and assessing risk. Because Risk Tolerance is value-based and associated with individual Risk Intelligence (See descriptions), and risk is a perception, not a competence, this term can lead to biases. (e.g., "Sam does not demonstrate risk competence" assumes Sam has the same value set as the organization. "Sam has a higher risk tolerance than the organization is comfortable with" would better describe Sam's values and be more helpful in developing proactive strategies to manage risk.	If describing organizational limits or views, use Organizational Risk Tolerance. If describing individual limits or views about risk, use Individual Risk Tolerance.
Event Reporting System	Event reports are seen as requiring a threshold to be crossed before reporting – often in proximity to harm, which can create an Outcome Bias.	In CHRO organizations, the term RISK REPORTING SYSTEM is used instead.
Root Cause Analysis	This phrase implies there is a singular cause to an event, which can bias the investigator and the organization. It also tends to influence people toward using the "5-Why's" approach instead of looking for specific <i>contributing factors</i> . This can lead to the analysis of issues that are far removed from direct or proximal contributors.	Collaborative Risk Reviews and Triad Reviews have demonstrated improved prevention results.

APPENDIX E –

Collaborative High Reliability® Organization Certification Outline





TIER 1-3 REQUIREMENTS

Tier 1 Certification requires the following:

- Collaborative Just Culture® Program qualification as a prerequisite;
- A Learning Management System documenting:
 - i) Collaborative High Reliability Organization (CHRO) education and proficiency; and
 - ii) Ongoing targets, measurements, and key results.
- A Reliability Management System documenting:
 - i) All components (activities, processes, programs, and systems) contributing to organizational high reliability;
 - ii) The primary purpose for each component;
 - iii) Ongoing targets, measurements, and key results for each component;
 - iv) A risk management plan for each component; and
 - v) Ongoing evidence that the Reliability Management System is sustainable and adaptable to changing conditions.

Tier 2 An organization shall have sustained organizational reliability over at least two years following successful Tier 1 certification.

Tier 3 An organization shall:

- Achieve previous Tier 1 and Tier 2 Certifications; and,
- Demonstrate advanced predictive reliability in at least two distinct areas of organizational performance.

Guidance:

Organizations may achieve Tier 2 and Tier 3 certification requirements concurrently.

RELIABILITY MANAGEMENT SYSTEM™

All three tiers of Organization Certification require developing a Reliability Management System (RMS): a collection of documented, aligned, and integrated processes, programs, and systems providing a structure for seeing, understanding, and managing organizational risk. Each component of the RMS is monitored and measured, providing an auditable standard of evaluation for sustainable organizational performance.

The first step in developing an RMS is to evaluate all organizational activities deemed necessary for high reliability, in accordance with the CHRO defining organizational attributes. Rather than stand-alone initiatives, each activity is examined to determine its purpose and to establish objectives and key results. Once determined, the activity is labeled according to the hierarchy of taxonomy terms as a process, program, system, or integrated system and then calibrated for inclusion in the Reliability Management System. The steps are as follows:

Evaluate all organizational activities deemed necessary for high reliability, in accordance with the CHRO organizational attributes. For each initiative:

1. Describe the purpose of the initiative. What risk(s) is the organization trying to see, understand and manage?
2. Is the initiative evidence-based?
 - a. If so, is the initiative documented?
 - b. If not, can the initiative become evidence-producing and submitted to scientific and/or industry review as a best practice?
3. Classify the initiative according to the hierarchy of terms (activity, process, program, system, or integrated system).
4. Align and integrate with other components of the RMS.
5. Monitor and measure performance of each component, as well as the combined result of each integrated system.

Reliability Management System

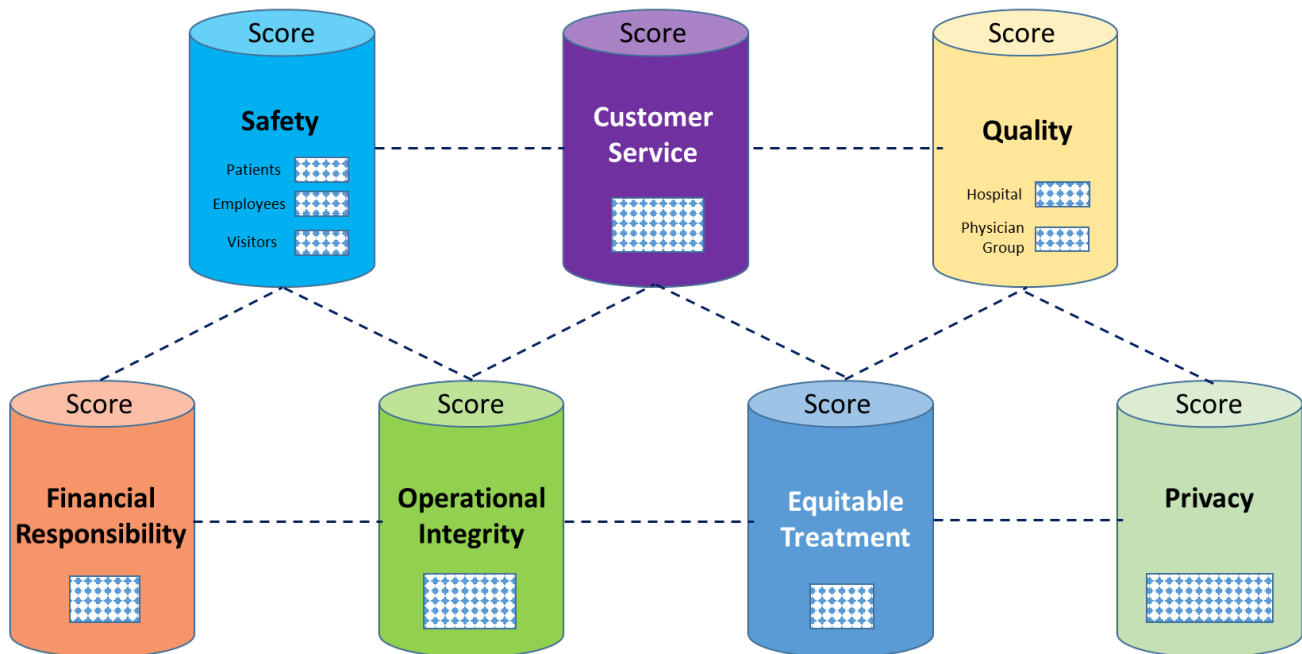


Figure 6

Once included in the RMS, these components can be correlated with the Sequence of Reliability as an aid to alignment and integration. The following questions are used in examining each component:

- Does this activity help us better **See and Understand Risk**?
- Will this activity help us better manage **Systems Reliability**? Will inclusion in the RMS help make systems more effective and/or resilient?
- Will this activity assist our Human Resources staff and help our leaders and supervisors better manage **Human Performance** and **Human Behavior**?
- Is the RMS documented, monitored, and measured? Are all components aligned and integrated? Can **Organizational Reliability** be sustained through continuous improvement?

Figure 7 below illustrates how many common existing processes, programs, and systems within a healthcare organization fit into a Reliability Management System:

1. See and Understand Risk	2. System Reliability	3. Human Reliability	4. Organizational Reliability
Organizational Attributes: • Safety (patient, employee, bystander) • Customer Service • Privacy • Quality • Finance • Operational Integrity • Equity Initiatives: • Risk Reporting • Risk Register • Collaborative Risk Review • Investigations • RCAs, FMEAs • Safety Huddles • Audits • Customer experience • Feedback loops • Others?	Evaluation and Design: • Are there macro- and sub-systems? • Are the systems effective when used as designed? • Are the systems resilient when things go wrong? • Can these systems be improved by elimination or re-design? Initiatives: • Resilient design • Policies, processes, procedures • Policy integration • Lean practices • Team-based care • Equipment • Others?	Performance Management: • Knowledge, skills, and abilities • System influences • Personal influences • Culture, perceptions of risk and competing priorities Behavior Management: • Are choices and errors managed consistently? Initiatives: • Leadership training • Employee support • Critical communication • Collaborative Just Culture Program • Online and classroom training • Employee support • Others?	Measurements: • Is the organization measuring this risk effectively across all departments? Sustainment: • Is the organization managing this risk on an ongoing basis? Is documentation provided? Initiatives: • Reliability Management Team • Objectives & Key Results (OKR) • Dashboards • Documentation • Triad Process • Collaborative Reviews • Predictive Systems • Others?

Figure 7