Don't Abandon Accountability

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Balancing "No-Blame" with Individual Accountability

- Elements of an effective patient safety system
- Who should be accountable for what?
- Managing accountability in a "no-blame" environment

To Err is Human

- Only a very small percentage of errors can be attributed to a person's lack of intellectual, physical or emotional ability
- The reason people fail to perform is that they work in a flawed system
- Simply blaming individuals is an expedient form of removing blame from the organization and effectively masks any latent flaws in it

Systems & Individuals

Creating a "no blame" culture: have we got the balance right?

M Walton

There is a need to clarify where and how professional responsibility fits into the "no blame" culture

How the media reports patient harm associated with adverse events continues to cause public concern and disturb health professionals. The need for health professionals to communicate more effectively with the public about medical errors has been identified,[1 2] but to date there is little evidence of this happening. Tensions surrounding professional responsibility and accountability (as opposed to institutional accountability) and the quality and safety "no blame" approach within the health system prevent health professionals communicating clearly with the public. How can we give a clear message to the public when we do not have a clear understanding of these issues ourselves?

The current focus on improving care by redesigning systems, tasks and workforce[3] necessarily emphasises the multiple factors underpinning errors, relies on reporting systems for capturing errors, and advocates a "blame free" environment so that staff will report their mistakes or near misses. This approach examines system factors as causes of errors rather than individuals. Evidence from other industries and disciplines supports this approach.

The safety agenda requires us to switch from an individual focus to a system focus but, in making this switch,

Just as it was wrong in the past to focus only on individuals, it is equally wrong today to think that all adverse outcomes are caused by systems problems with no attention to professional duties and responsibilities.

Reference: Walton M. Creating a 'no blame' culture: have we got the balance right? *Quality and Safety in Health Care* 2004;13:163–4.

Accountable and "No-Blame" are Not Mutually Exclusive

- **Accountable:** *Answering for one's own conduct and obligations, meeting commitments, doing what you say you're going to do.*
- **No-Blame:** *People who make honest mistakes or misjudgments will not incur blame. People who fail to act responsibly (e.g. premeditated or intentional unsafe acts or decisions involving a reckless disregard toward the safety of patients) remain exposed to consequences.*

Patient Safety System

The system by which the governing body, senior leaders, managers and staff members share **responsibility** and are held **accountable** for the safety of patient care.

From ***Boardroom*** 

to ***Bedside!*** 

What is Accountability?

Individual Accountability =

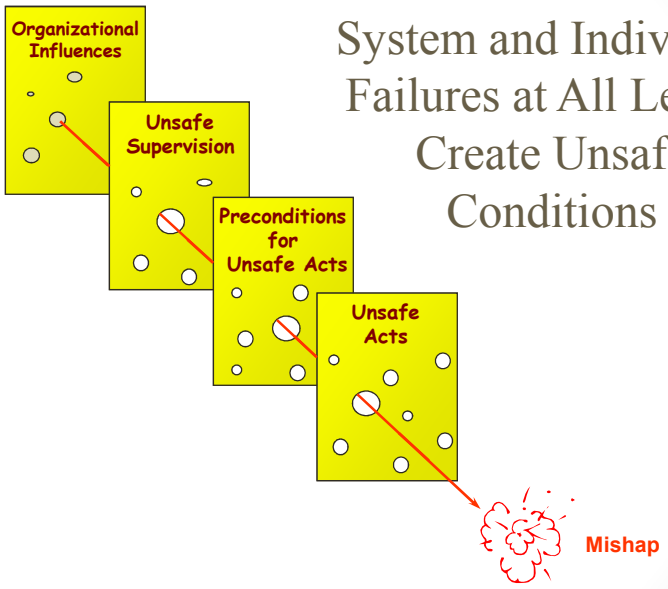
Responsibility + Evaluation ⇨ Consequences

The condition of accountability exists

when you have defined responsibilities

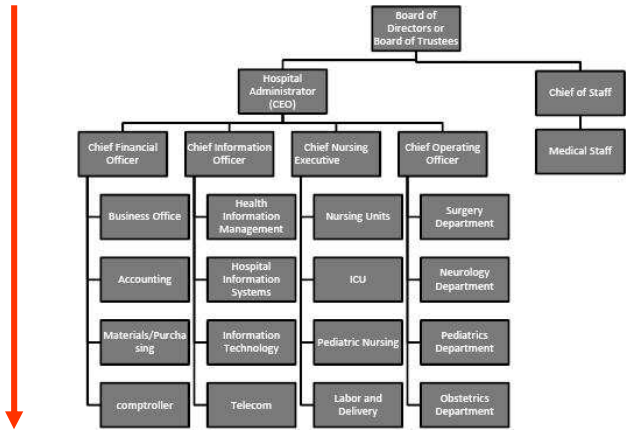
and your performance is evaluated

and it results in consequences

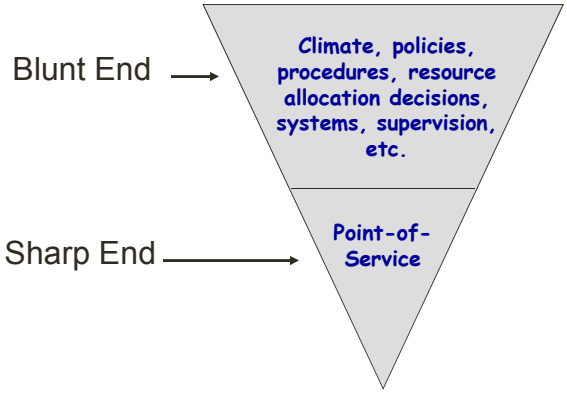


System and Individual Failures at All Levels Create Unsafe Conditions

System improvements and individual accountability are needed at all levels



Accountable for What?



Patient-Safe Culture

Board, senior leaders, and managers are accountable for keeping patient safety in the forefront

- Discuss it
- Encourage it
- Demonstrate it
- Evaluate it
- Train it

Accountable for Personal Involvement

- *Executive Walk Arounds* at Memorial Hermann Hospital (Houston)
  - Participants: 2 VPs and 4 Assistant VPs. Patient Safety Officer and PI Dept. staff member accompanied VP during scheduled unit visits
  - Baseline safety climate survey of staff: 76.78 (61% positive)
  - After initiating EWRs, mean climate score for those who participated was 8.1.02 (72.9% positive).

Reference: Thomas, EJ et al. The effect of executive walk rounds on nurse safety climate. *BMC Health Services Research* 2005, 5:28 This article is available from: http://www.biomedcentral.com/1472-6963/5/28

Patient-Safe Systems

Board, senior leaders, managers, physicians and staff are accountable for creating safer systems

- Resources
- Simplify
- Computerize
- Discover
- Measure
- Engage

Accountable for Timely Implementation of Safe Practices

In Fall 2004 a 69-year-old woman was having a coil placed under cerebral angiography to repair a brain aneurysm when she was accidentally injected with an antiseptic skin prep solution, chlorhexidine, instead of contrast media. Both solutions were clear and available on the sterile field in unlabeled basins. Within 2 hours she experienced an acute, severe chemical injury to the blood vessels. During the following 2 weeks, the patient's condition deteriorated. She underwent a leg amputation, and then suffered a stroke and multiple organ failure, which led to her death.

Accountable for Timely Process Improvements

Root Cause Analysis Action Plan

Event Description	Actions	Responsible party	Date Due
Treatment delay – EKG transmission/ interpretations	1) Standardize the EKG interpretation process for physicians. 2) Modify transmission process at offsite locations (add modem connections) 3) Obtain software upgrade to enable results tracking.	1) VPMA 2) Diagnostic Center Manager 3) Non-invasive Cardiology Director	1) June 1 2) May 15 3) July 1
Treatment delay – CPR/ resuscitation	1) RT to ensure that dual oxygen flowmeters available in room with pt with artificial airway 2) Distributed article on "performance in complex organizations" to emphasize ALL persons responsibility to ensure patient safety. 3) Add to CPR review ability for RT to report any equipment problems identified during review. 4) Incorporate hands-on examples into CPR training.	1) Respiratory Therapy Director 2) Chief Nurse Exec 3) CPR committee 4) Clinical Education Dept. Director	1) Sept. 1 2) Aug. 15 3) Sept. 15 4) Nov. 1

Patient-Safe Tasks

Those at the "sharp end" are accountable for:

- Being fit for duty during their work time
- Reporting incidents, near misses and patient safety concerns
- Exerting positive peer pressure to reinforce safe work practices
- Conducting their duties in such as way as to avoid harm to patients
  - Accurately completing critical tasks *or* stopping the process when a critical task cannot be completed as required

Critical Tasks or "Red Rules"

A "red" rule is something that except in a rare, urgent situation, we should be doing every time it is indicated within a particular process of caring for a patient.

Cassy Horack, RN, Director Patient Safety, OSF Saint Francis Medical Center, Peoria, IL

Service Area	Red Rule
Central line insertion	Maximal sterile barrier will be established
Circumcision	Analgesia must be used during the procedure
Invasive procedures	Clean surgery scrubs will be available in all areas
Operating room	Timeouts shall be performed prior to all procedures

Source: *If You Do Nothing Else, Do These Ten Things!* Presentation by M. Bisognano and R. Lloyd at 17th Annual IHI National Forum on Quality Improvement in Health Care, Dec. 2005

Red Rule Violations

Non-compliance leads to a visit with the CEO and members of the medical executive team. The medical executive team passed the red rules.

John Whittington, MD, OSF Saint Francis, Peoria, IL

The definition we use for "non-compliance" is that our employee knew the rule, thought about it at the time, and made a conscious decision not to follow the rule. The consequence for non-compliance is a minimum of a written warning.

Carole Stockmeier, Director of Safety Initiative at Sentara Healthcare, an integrated health care provider in SE Virginia and NE North

Source: *If You Do Nothing Else, Do These Ten Things!* Presentation by M. Bisognano and R. Lloyd at 17th Annual IHI National Forum on Quality Improvement in Health Care, Dec. 2005

Responsibility + Evaluation

Responsibility	Evaluation
Provide adequate staff	• % of shifts that lacked adequate staff (as defined by staffing plans) • Monthly average of paid overtime hours for direct patient care staff
Promote patient safety improvement activities	• # of proactive patient safety improvement projects completed annually
Support a patient-safe culture	• # of leadership walk-arounds conducted • Rate of incident/near reporting • Results of culture surveys
Ensure staff are trained to safely conduct their job assignments	• # of patient incidents caused by lack of staff knowledge/training • % of staff provided job-specific safety training prior to start of job assignment
Provide adequate rest time for staff	• % of staff who get regularly scheduled 10- to 15-minute complete breaks from work
Correct known safety concerns	• % of action plans implemented by target date • Timeliness of implementation of "best practice" patient safety recommendations

Accountability Avoidance

- Problematic situations:
  - Rather than ask for progress reports on improvement actions, wait (and hope) that people will measure their own progress
  - No set reporting schedule; people can decide when and how to report
  - Avoid unpleasant confrontation that might result from an unacceptable progress report
  - Allow skeletons to remain in the closet, rather than squarely face troublesome issues that are getting the way of improvements
  - Tolerate excuses for poor results – hoping the problem will fix itself overtime
  - Insufficient clarification of expectations on the front end resulting in vague progress reports

Responsibility + Evaluation ⇨ Consequences

- Positive reinforcement – Individual performs to receive the consequence
  - "If I report an unsafe situation, I will be recognized."
- Negative reinforcement – Individual performs to avoid the consequence
  - "If I complete the improvement project on time, I won't be reprimanded."
- Absence of consequences – Individual performs without expectation of consequences
  - "It doesn't matter how hard I work around here."

Take-Home Message

A no-blame environment and individual accountability are <u>not</u> mutually exclusive

- "No-blame" environment
  - It is safe for people to bring problems and mistakes out of the closet so they can be solved and prevented in the future
  - Individuals are not blamed for system failures
- Individual accountability
  - Clearly specify responsibilities and who will do what
  - Evaluate to determine if responsibilities are being met
  - Respond if it doesn't work out (Eliminate the "oh wells"!)

Thank You

Be Safe

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