ELEMENTS OF ACCOUNTABILITY

Accountability for the Clinician/Practitioner	**Accountability for the Healthcare Organization Management/Leaders**	**Accountability for Regulators/Accreditors**
Understanding that patient safety is a serious problem, the clinician actively works toward creating a culture of safety in his/her practice setting by identifying behaviors that prevent or mitigate error and by speaking up about behaviors or systems that are unsafe.	*Committed to maintaining a fair, just and accountable culture, organization leaders ensure the presence of structures and processes for patient safety that are comprehensive, highly effective and involve patients and families as partners in care. Ongoing communication with all regulatory bodies achieves consensus and standardization of reporting policies and procedures.*	*Guided by principles of a fair, just and accountable culture, regulatory bodies work with each other and with organization leaders to establish a framework for the regulation of respective practices and healthcare settings that is explicit to all stakeholders, comprehensive, timely and coordinated among the different regulatory bodies.*
PROSPECTIVE – During the delivery of health care services		
Error Reduction 1. Follows the safety literature 2. Supports and promotes error detection efforts *by speaking up about unsafe conditions* 3. *Follows safety practices and changes* practices *as necessary* to enhance safety 4. Facilitates the implementation of proactive steps to reduce errors based upon known error prevention strategies and human factors science 5. Consistently provides patient/*family* education *so that patients and families participate in creating a safe environment* **Individual Professional Practice** *1. Realizes that assuring patient safety is a problem* *2. Changes focus from risk management to patient safety* *3. Works toward creating a culture of safety in the organization*	**Promotes Patient Safety** 1. Positions "patient safety" as a *separate* priority/prerequisite in mission 2. Declares publicly and through actions that safety is job one 3. *Assigns clear responsibility and resources to ensure structures and processes within the organization to ensure patient safety* 4. With the goal being zero injuries (not zero errors), *continue building systems to prevent error; near miss situations need to be analyzed and understood, and involved staff need to be supported* *5.* Partners with patients and families *to assure them that the environment is safe* *6. Assures that staff know how to deal with family's anger and assure that concerns are followed up* 7. Promotes proactive CQI activities using data from error reporting programs; *works with regulators and*	**Supports Patient Safety Activities** 1. *Makes framework for review explicit to all stakeholders* 2. *Lengthens the timeframe for reporting so that all details can be understood and real learning can occur (the process of investigation affords greatest opportunities for learning)* 3. *All groups should use a common language, coordinate processes in a timely manner* 4. *Human factors engineering principles should guide review processes* 5. *Establishes different venues for reporting near misses or harm* 6. Promotes continuous quality improvement activities at the practice site 7. Promotes system-based safety recommendations and provides oversight to assure they are observed 8. Utilizes data from national reporting programs since errors are similar from one state to another. 9. Establishes patient safety CE requirements

4. *Becomes actively involved in understanding what causes error* 5. Recognizes the important role he or she plays in patient safety 6. Seeks education to maintain competencies 7. Asks for help when necessary 8. Never believes errors won't happen 9. Never believes anyone is capable of practicing without making errors 10. *Sees oneself as a member of the team;* provides support for colleagues who make errors 11. Changes the conditions that induce errors 12. Identifies behaviors that prevent or mitigate error; *speaks up if sees behavior affecting patient safety* 13. Identifies responsibilities of accountable clinicians 14. *Understands own accountability in the framework of the healthcare team* 15. *Reports unsafe or reckless behavior*	*accreditors to standardize reporting policies and procedures;* QI reviews include errors, near misses and hazardous conditions from incidents reported internally and to USP-ISMP-FDA or other voluntary programs 8. Addresses safety *at every meeting and* when implementing new protocols, procedures, redesigned services, new medications 9. Establishes safe workloads and assures proper breaks; *continues to evaluate rightness of workload with input from the front line* 10. Incorporates technology for efficiency and safety; *provides training to overcome resistance to new technology* 11. Provides adequate technician support for technology 12. Establishes baseline competencies and adequate orientation period 13. *Builds and maintains robust program for assuring continued competence and credentialing* 14. *Assures competence of per-diem and non-regular staff* 15. *Educates staff to deal with high-risk situations* 16. *Takes appropriate action with incompetent staff* 17. Distinguishes between error and incompetence 18. *Investigates consumer complaints* **Shares Stories and Disseminates Results** 1. Provides staff with "safety briefings" and communicates directly with staff to inform about potential errors and safety enhancements and to learn about improvement needs 2. Communicates *effectively and in multiple vehicles* about errors and	10. Facilitates use of proper performance measurement systems that establish baseline competency 11. Works with schools and professional organizations to promote proper training and understanding of system analysis and error prevention methods 12. Recognizes peer review protection is critical for error reporting and quality improvement data sharing; *this will require new legislation – should look to North Carolina model* 13. Educates public about system-based causes of errors 14. *Clarifies organizational vs. individual accountability* 15. *Differentiates between rule violation and harm and recognize that the public expects protection from incompetent practitioners* 16. Promotes national acceptance of error management activities 17. Investigates consumer complaints and stimulates appropriate actions **Shares Stories and Disseminates Results** 1. Offers at least quarterly meetings to share information and ideas 2. *Shares aggregate learning and improvement plans among agencies* 3. *Determines how to prevent disciplinary arm from stifling learning* 4. *Determines whether regulatory body has a role with patients and families* 5. Communicates in newsletters about errors and prevention methods, not rule violations

	prevention methods	
RETROSPECTIVE – After an adverse event occurs		
Error Detection and Reporting 1. *Fully participates in analysis of adverse event and managing consequences* 2. Programs have legal protections from discovery to encourage reporting 3. Speaks out about safety issues 4. *Openly* communicates ideas about error prevention with colleagues; *event should be tied to education about potential or real harm* 5. Provides support for colleagues who make errors 6. Determines need for staff and patient/family support 7. *Clinician should be rewarded for reporting adverse events or processes that may cause harm* **Disclosure/Communicating about Errors** 1 *Clinician takes responsibility for own actions and* voluntarily reports errors to established programs 2 Shares personal knowledge of "what went wrong" after involvement in an error and provides "expert" recommendations for prevention; *recognizes that problem is not always a systems issue* 3 *Five steps for clinician/practitioners:* • *tell what happened;* • *report and manage;* • *take responsibility;* • *educate patient and family* • *apologize (this can fall to*	**Promotes error reporting** 1. *Conducts a complete RCA, keeping focus on what to learn from the incident* 2. *Distinguishes between error and incompetence* 3. *Gathers appropriate individuals including staff involved in error* 4. *Fixes the problem; closes loop to be sure error doesn't happen again* 5. Rewards practitioners for reporting errors 6. Maintains confidentiality of individuals involved in an error *7. Uses learning to set up system redesign* **Provide support after an error** 1. Provides support to colleagues, clinicians, and staff who make errors; *considers past work history in review* 2. Determines need for patient/family support **Disclosure/Communicating about Errors** 1. *Assures that all groups in organization have access to data to "mesh" stories* 2. Promotes error reporting to internal and external programs; *considers when to suggest 3rd party review* 3. *Engages in consultative and collaborative discussion with regulators about how to proceed; tries to eliminate silos and find comfortable zone for discussion (recognizes inherent tension because regulators may have to take action and disclose information)*	**Promote the adoption of a statewide system for error management and reporting** 1. Distinguishes between error and incompetence and places errors into categories: a. Proficiency b. Communications and decision errors – team training c. Procedural errors, human limitations, inadequate procedures 2. Distinguishes between regulatory/statutory violations and errors 3. Identifies cultures of non-compliance, perceptions of invulnerability, poor procedures 4. Limits sanctions to egregious misconduct, impairment, criminal activity; *makes available opportunities for remediation* 5. Recognizes differences between QC, QA, CQI, and actions needed in immediate aftermath of a critical error 6. Acknowledges hazard of "hindsight bias" 7. Gathers appropriate individuals, including staff involved in errors (who may not be available in immediate aftermath) and *recognizes subjectivity in individual's understanding of what happened* 8. *Insures that support is available for individual and that the individual is accountable for using the system* 9. *Boards and DPH should coordinate investigation and conclusions* 10. Educates the public about system-based causes of errors 11. *Rewards organizations for reporting medical errors and promoting patient safety;* 12. *Leadership of organization is evaluated (licensed?) on patient safety issues* **Disclosure/Communicating about errors**

clinician or someone from system)		1. *Determines proper reporting mechanism to public (recognizing that press may have different objectives)* 2. Communicates in media about errors and prevention methods, not rule violations; *shares knowledge of what went wrong, not who did what* 3. Names of involved practitioners, pharmacies *and patients and families* held in confidence; *clarifies who is responsible for disclosure* 4. *Determines appropriate way to disseminate information to attorneys*

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