<table>
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<th>ELEMENTS OF ACCOUNTABILITY</th>
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<td><strong>Accountability for the Clinician/Practitioner</strong></td>
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<td>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.</td>
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| **Accountability for the Healthcare Organization Management/Leaders** |
| 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. |

| **Accountability for Regulators/Accreditors** |
| 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
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<td>4. Becomes actively involved in understanding what causes error</td>
<td>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</td>
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<td>5. Recognizes the important role he or she plays in patient safety</td>
<td>8. Addresses safety at every meeting and when implementing new protocols, procedures, redesigned services, new medications</td>
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<td>6. Seeks education to maintain competencies</td>
<td>9. Establishes safe workloads and assures proper breaks; continues to evaluate rightness of workload with input from the front line</td>
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<td>7. Asks for help when necessary</td>
<td>10. Incorporates technology for efficiency and safety; provides training to overcome resistance to new technology</td>
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<td>8. Never believes errors won’t happen</td>
<td>11. Provides adequate technician support for technology</td>
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<td>9. Never believes anyone is capable of practicing without making errors</td>
<td>12. Establishes baseline competencies and adequate orientation period</td>
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<td>10. Sees oneself as a member of the team; provides support for colleagues who make errors</td>
<td>13. Builds and maintains robust program for assuring continued competence and credentialing</td>
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<td>11. Changes the conditions that induce errors</td>
<td>14. Assures competence of per-diem and non-regular staff</td>
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<td>12. Identifies behaviors that prevent or mitigate error; speaks up if sees behavior affecting patient safety</td>
<td>15. Educates staff to deal with high-risk situations</td>
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<td>13. Identifies responsibilities of accountable clinicians</td>
<td>16. Takes appropriate action with incompetent staff</td>
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<td>14. Understands own accountability in the framework of the healthcare team</td>
<td>17. Distinguishes between error and incompetence</td>
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<td>15. Reports unsafe or reckless behavior</td>
<td>18. Investigates consumer complaints</td>
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<td>Shares Stories and Disseminates Results</td>
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<td>1. Offers at least quarterly meetings to share information and ideas</td>
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<td>2. Shares aggregate learning and improvement plans among agencies</td>
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<td>3. Determines how to prevent disciplinary arm from stifling learning</td>
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<td>4. Determines whether regulatory body has a role with patients and families</td>
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<td>5. Communicates in newsletters about errors and prevention methods, not rule violations</td>
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**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
**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

**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. 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

**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**

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)
| **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* |

With thanks to Michael Cohen, from the Institute for Safe Medication Practices; many of these elements are from a presentation he gave.