California Association of Public Hospitals and Health Systems

California Health Care Safety Net Institute

Sepsis & CLABSI Collaborative: "Accountability"

May 20, 2013

Cynosure HEALTH

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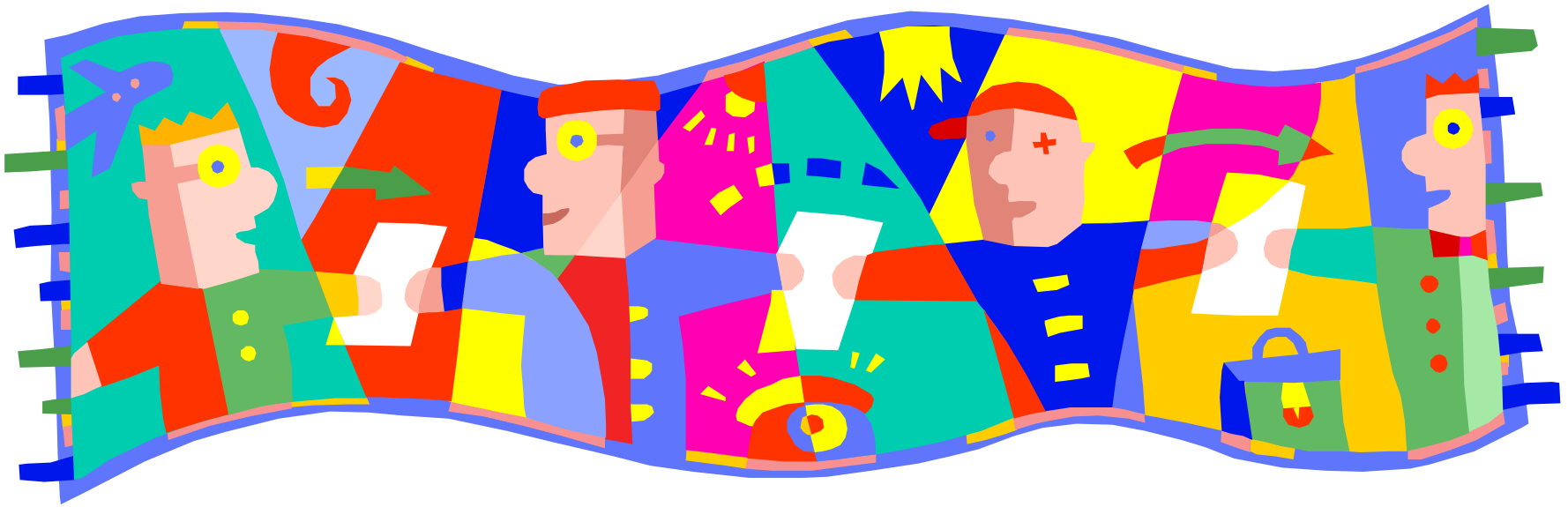
Today's Topic: Accountability

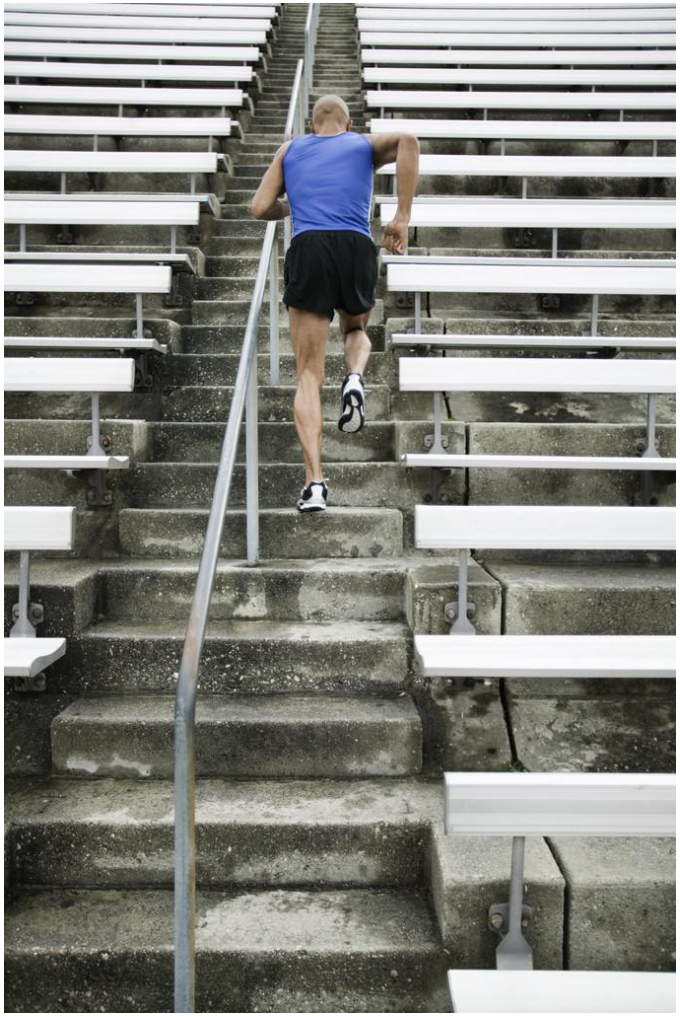


Contributors to Today's Webinar

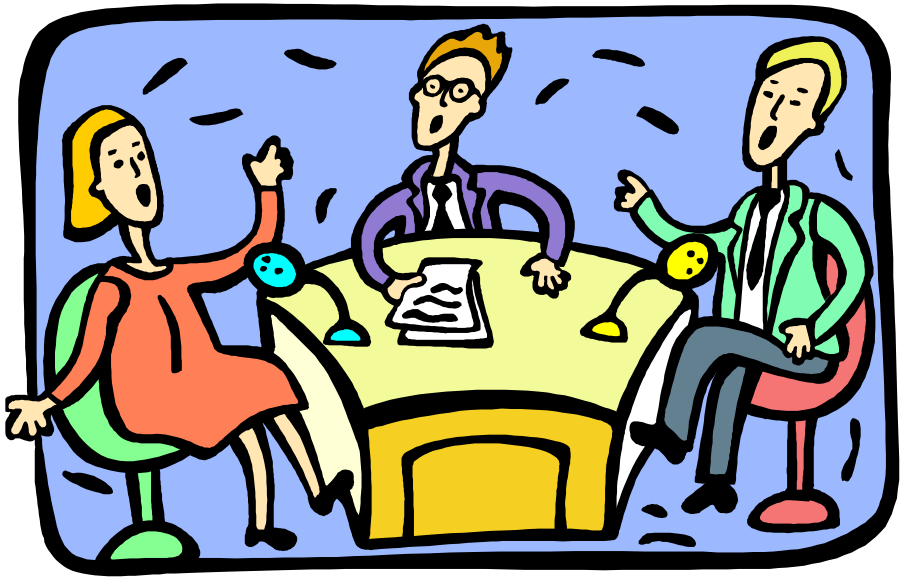
- Rick Rutherford, MD from Ventura
- Mark Leary, MD from SFGH
- Doug Bonacum from Kaiser Permanente

Rick Rutherford, MD from Ventura

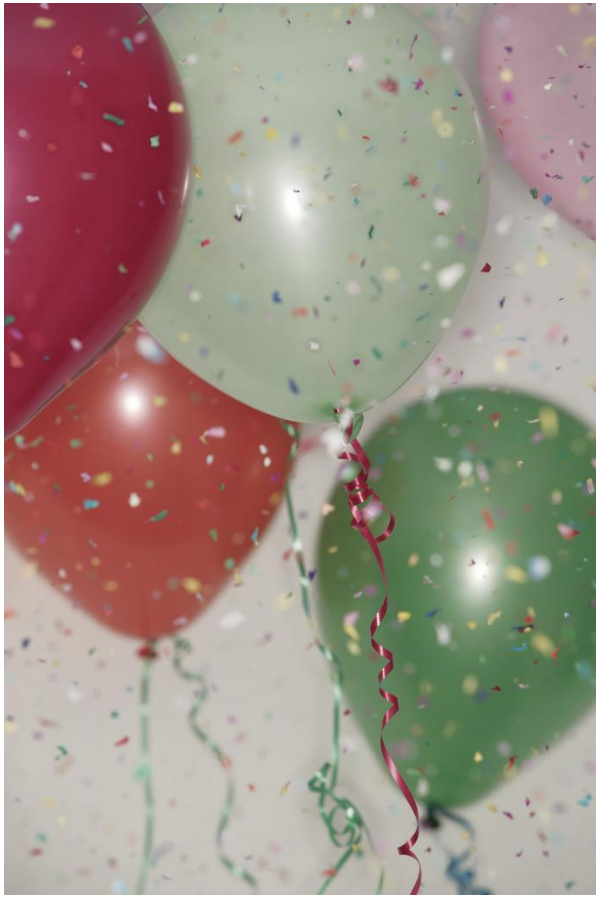
Accountability Journey



From Closed Doors to This……



Sharing of News/Feedback to Clinicians



Team Approach

Culture of Responsibility

Keys to Success

Mark Leary, MD from SFGH

SFGH's Fair and Just Culture Journey

San Francisco General Hospital & Trauma Center

Transforming Health Care at SFGH 2011-2016

Our Mission To provide quality health care and trauma services with compassion and respect

Our Vision Advance community wellness by aligning care, discovery, & education

People
Clinical & Service Excellence

Service Excellence
Create an organizational structure where staff are engaged - in partnership with patients and families - to achieve excellence in communication, patient-centered care, operational efficiency, and quality patient care.

Clinical Quality
Improve patient care through collaboration, accountability, and accurate measurement and reporting.

Professional & Academic Excellence
Create and sustain an environment of professional excellence in all disciplines. Ensure a supportive and enriching environment for training in clinical care.

Safety and Accountability
Enhance a culture of shared responsibility where SFGH is accountable for the systems it designs and for responding to the behaviors of staff in fair and just manner.

Enhancing Wellness
Enhance the health of patients and staff through a Wellness Initiative that promotes healthy lifestyles, active living, and emotional, physical, and spiritual well-being.

Tech
Meaningful Information

Moving beyond "implementation" towards "adoption" of HIT
Improve quality, safety, and efficiency through improved data collection, information exchange, and clinical decision support. Ensure that technologies align with SFGH principles of patient safety and quality of care.

(>90% orders on CPOE) by end of 2012

- Complete roll-out of MAK (electronic medication administration record) to all medical-surgical units and Psychiatry by end of 2012
- Successful implementation of Ambulatory Electronic Medical Record.
- Create Quality Data Center by summer 2012

Case Study

A Radiology Technologist assigned to CT Scan has received a demented patient on falls precautions from med/surg for a CT of the abdomen. Upon arrival to Radiology, the technologist places the side rails down on one side of the gurney to prepare the patient. At this moment (as happens periodically), the technologist gets called urgently to the front desk and does not put the side rails up. When he returns the patient is off the gurney walking with an unsteady gait down the hallway. The technologist assists the patient back to the gurney without incident. The shift supervisor walks by and observes the incident, but does not say anything.

Today, a different technologist assigned to CT has the same patient brought to Radiology for a Head CT. He also puts the side rails down to prepare the patient. The technologist gets called urgently to MRI and does not put the side rails up. When he returns the patient is found on the ground, yelling in pain, with an open fracture of the femur. The Radiologist and IR nurse respond to the patient and the medical team is called. The technologist was placed on administrative leave, awaiting disciplinary action.

Intent for the Fair and Just Culture Task Force

To fulfill the SFGH mission and manifest our shared values, through a consistent, thoughtful assessment of human interactions at the interface between **system design** and **behavioral choices**.


People
The Syste
The Patient 1st

A Fair and Just Culture supports a learning culture that focuses on proactive management of ***system design*** and management of ***behavioral choices.***

Bi-directional Accountability

SFGH leadership
Systems design/maintenance
Cultivate honest, fair feedback
Consistent execution of just culture

⇔

SFGH Staff
Behavioral choices informed by SFGH policies
Engage in honest, fair feedback

TRUST – HUMANISTIC CARE

The Three Behaviors

Human Error
An inadvertent action doing other than what should have been done; slip; lapse

⇩

Console

At-Risk Behavior
A choice that increases risk which is not recognized or believed insignificant

⇩

Coach

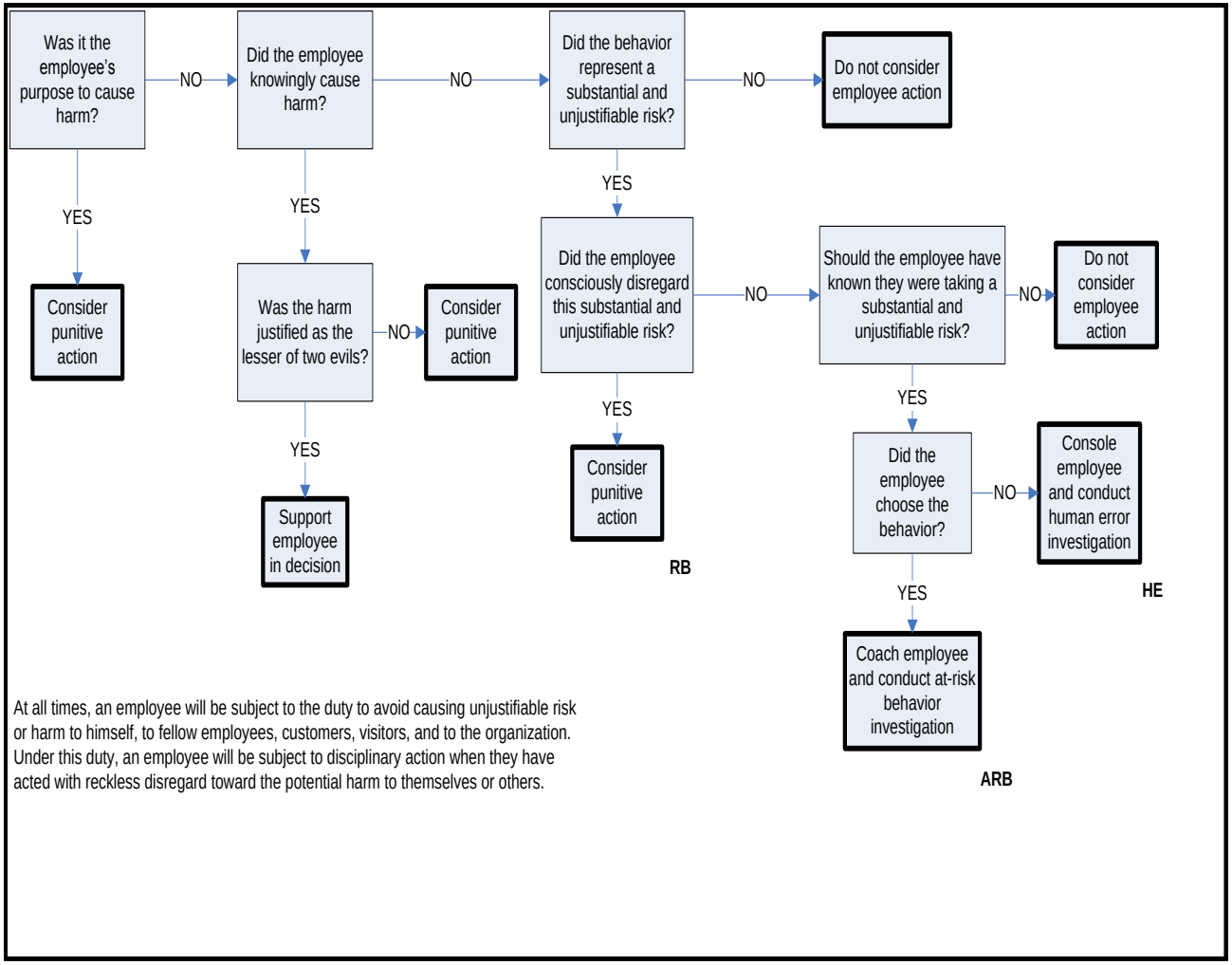
Reckless behavior
A conscious disregard of substantial and unjustified risk

⇩

Discipline

JUST CULTURE ALGORITHM

Duty to Avoid Causing Unjustifiable Risk or Harm



At all times, an employee will be subject to the duty to avoid causing unjustifiable risk or harm to himself, to fellow employees, customers, visitors, and to the organization. Under this duty, an employee will be subject to disciplinary action when they have acted with reckless disregard toward the potential harm to themselves or others.

Actions

	With System	With Employee
Human Error (HE)	Modify system performance shaping factors	Console employee; Remedial action
At-Risk Behavior (ARB)	Modify system performance shaping factors	Coach employee; Remedial action
Reckless Behavior (RB)		Punitive action; Remedial action

Interested in sharing A Fair an Just Culture with your staff?

Contact us to present at your next staff meeting

Creating a Different Type of "Accountable Care Organization"

Doug Bonacum
VP Quality, Patient Safety, and Resource Stewardship

Accountability Journey: 2001 - Today

- Accountability “inflection point” began with a commitment to saying “Sorry”
- Fostering a “Just Culture”
  - Adapting the “Just Culture” Algorithm
  - National Bargaining Agreement
- Measuring Safety Culture
- Transparency Journey
- Education and Training
- Accountable practices for:
  - Front Line
  - Middle Management
  - Executives
- Hardwiring Hard Stuff
- Game Changer - Patient and Family Centered Care

Mirror, Mirror on the Wall

- What do you do to hold yourself accountable?
- How does your boss hold you accountable?
- How do your customers/working partners hold you accountable?

So Why Then….

- When we talk about accountability, most of us go here:

Saying “Sorry” - Communicating Unanticipated Adverse Outcomes

- When patients are harmed by our care, they want three things
  - A timely and truthful explanation of the event and its effects
  - An expression of sympathy or an apology when medical error contributed to the harm
  - A description of what we are doing to minimize the event from recurring
- A project team and advisory group was established in June 2001 to develop a statement of principle and supporting guidelines for communicating to our patients about adverse events.

Saying “Sorry” - Statement of Principle

Patient care should be reliable, effective, and safe. Patient safety is every patient’s right and every leader’s, employee’s and clinician’s responsibility. It is an ongoing and relentless commitment to continuing to build safer systems. Despite constant and committed efforts to provide safe health care, from time to time, patients experience unanticipated adverse outcomes.

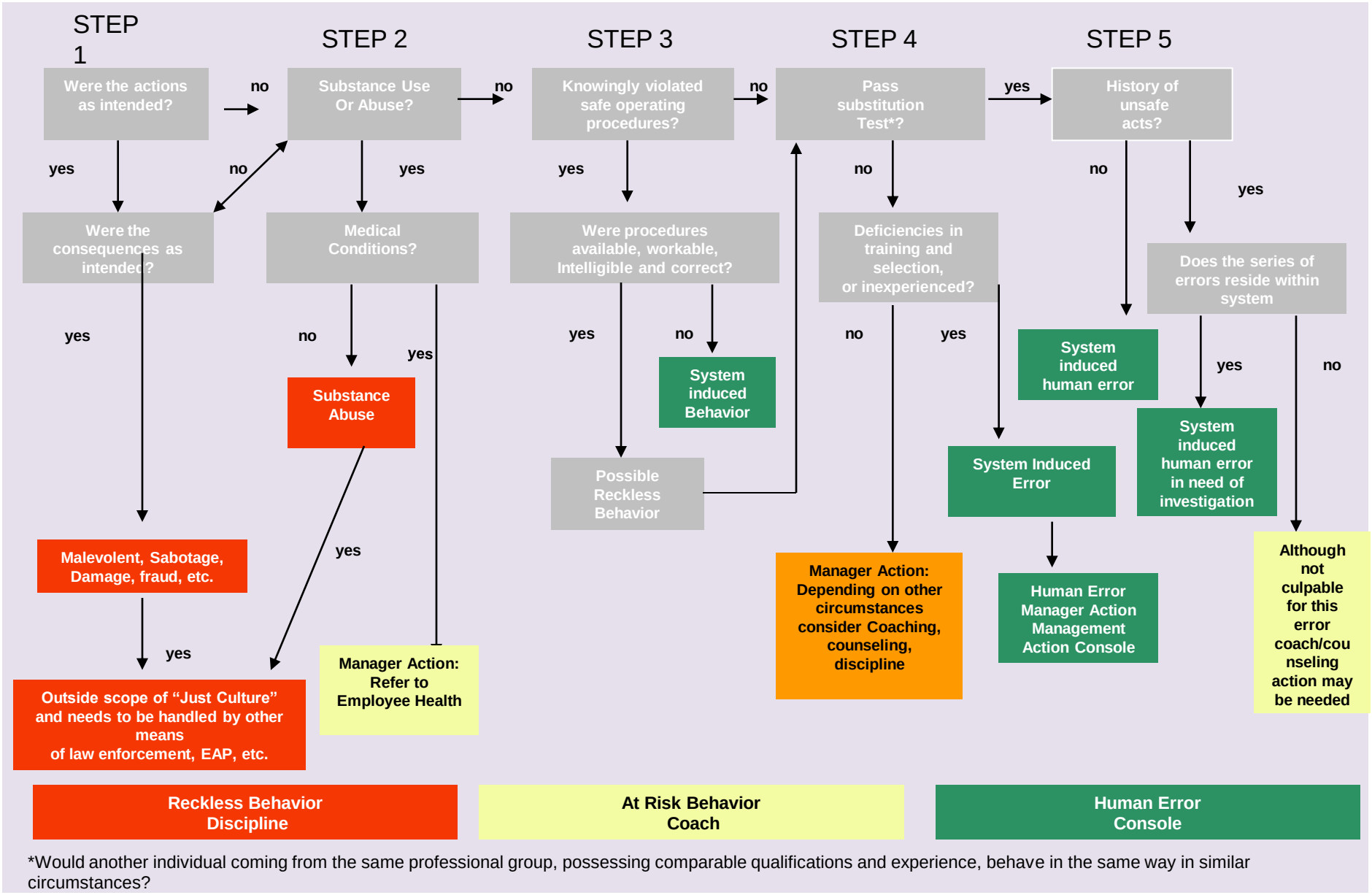
To fulfill our commitment to our patients, “Quality You Can Trust”, we embrace our responsibility and acknowledge our ethical obligation to communicate with our patients when unanticipated outcomes have occurred. When such an outcome occurs, the patient, or the patient’s health care representative, has a right to an explanation of the outcome and its effects, provided in a timely, truthful and compassionate manner.

Human systems periodically align and combine to contribute to unanticipated adverse outcomes for patients. The decisive factor will be the manner in which we handle these events. Patient safety and clinician welfare will be best served if we are honest about unanticipated adverse outcomes with our patients, open with our colleagues and ourselves, and if we handle such occurrences with sympathy and empathy for our patients and our colleagues.

Fostering a Just Culture

- Kaiser Permanente's National Bargaining Agreement
- Just Culture Algorithm

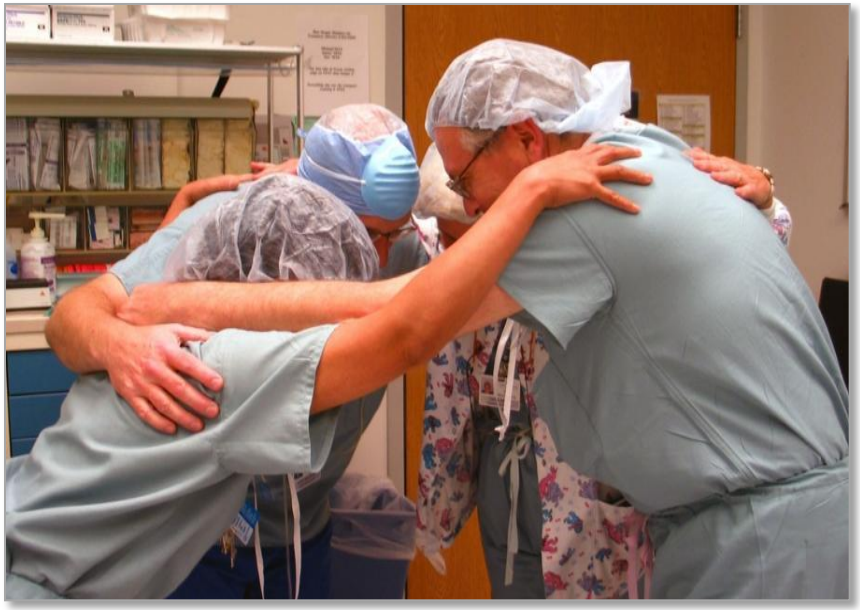
Just Culture - Adopted from James Reason "Managing the Risks of Organizational Accidents" and work of David Marx



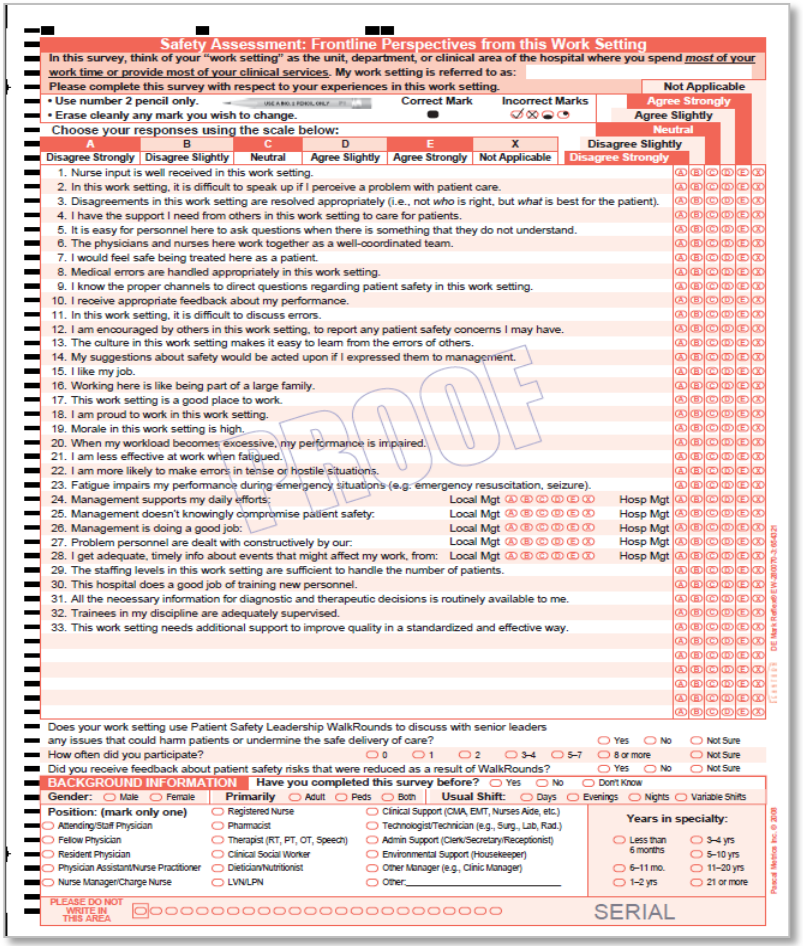
*Would another individual coming from the same professional group, possessing comparable qualifications and experience, behave in the same way in similar circumstances?

Measuring Safety Culture

Shared values and beliefs that interact with an organization's structures and control systems to produce behavioral norms



Safety Attitudes Questionnaire (SAQ)



Safety Assessment: Frontline Perspectives from this Work Setting

In this survey, think of your "work setting" as the unit, department, or clinical area of the hospital where you spend *most of your work time or provide most of your clinical services*. My work setting is referred to as:

Please complete this survey with respect to your experiences in this work setting.

- Use number 2 pencil only.
- Erase cleanly any mark you wish to change.

Correct Mark | Incorrect Marks

Choose your responses using the scale below:

A	B	C	D	E	X
Disagree Strongly	Disagree Slightly	Neutral	Agree Slightly	Agree Strongly	Not Applicable

Not Applicable | Agree Strongly | Agree Slightly | Neutral | Disagree Slightly | Disagree Strongly

1. Nurse input is well received in this work setting.
2. In this work setting, it is difficult to speak up if I perceive a problem with patient care.
3. Disagreements in this work setting are resolved appropriately (i.e., not *who* is right, but *what* is best for the patient).
4. I have the support I need from others in this work setting to care for patients.
5. It is easy for personnel here to ask questions when there is something that they do not understand.
6. The physicians and nurses here work together as a well-coordinated team.
7. I would feel safe being treated here as a patient.
8. Medical errors are handled appropriately in this work setting.
9. I know the proper channels to direct questions regarding patient safety in this work setting.
10. I receive appropriate feedback about my performance.
11. In this work setting, it is difficult to discuss errors.
12. I am encouraged by others in this work setting, to report any patient safety concerns I may have.
13. The culture in this work setting makes it easy to learn from the errors of others.
14. My suggestions about safety would be acted upon if I expressed them to management.
15. I like my job.
16. Working here is like being part of a large family.
17. This work setting is a good place to work.
18. I am proud to work in this work setting.
19. Morale in this work setting is high.
20. When my workload becomes excessive, my performance is impaired.
21. I am less effective at work when fatigued.
22. I am more likely to make errors in tense or hostile situations.
23. Fatigue impairs my performance during emergency situations (e.g. emergency resuscitation, seizure).
24. Management supports my daily efforts: Local Mgt / Hosp Mgt
25. Management doesn't knowingly compromise patient safety: Local Mgt / Hosp Mgt
26. Management is doing a good job: Local Mgt / Hosp Mgt
27. Problem personnel are dealt with constructively by our: Local Mgt / Hosp Mgt
28. I get adequate, timely info about events that might affect my work, from: Local Mgt / Hosp Mgt
29. The staffing levels in this work setting are sufficient to handle the number of patients.
30. This hospital does a good job of training new personnel.
31. All the necessary information for diagnostic and therapeutic decisions is routinely available to me.
32. Trainees in my discipline are adequately supervised.
33. This work setting needs additional support to improve quality in a standardized and effective way.

Does your work setting use Patient Safety Leadership WalkRounds to discuss with senior leaders any issues that could harm patients or undermine the safe delivery of care? Yes / No / Not Sure

How often did you participate? 0 / 1 / 2 / 3–4 / 5–7 / 8 or more / Not Sure

Did you receive feedback about patient safety risks that were reduced as a result of WalkRounds? Yes / No / Not Sure

BACKGROUND INFORMATION Have you completed this survey before? Yes / No / Don't Know

Gender: Male / Female

Primarily: Adult / Peds / Both

Usual Shift: Days / Evenings / Nights / Variable Shifts

Position: (mark only one)

- Attending/Staff Physician
- Fellow Physician
- Resident Physician
- Physician Assistant/Nurse Practitioner
- Nurse Manager/Charge Nurse
- Registered Nurse
- Pharmacist
- Therapist (RT, PT, OT, Speech)
- Clinical Social Worker
- Dietician/Nutritionist
- LVN/LPN
- Clinical Support (CMA, EMT, Nurses Aide, etc.)
- Technologist/Technician (e.g., Surg., Lab, Rad.)
- Admin Support (Clerk/Secretary/Receptionist)
- Environmental Support (Housekeeper)
- Other Manager (e.g., Clinic Manager)
- Other:

Years in specialty:

- Less than 6 months
- 6–11 mo.
- 1–2 yrs
- 3–4 yrs
- 5–10 yrs
- 11–20 yrs
- 21 or more

PLEASE DO NOT WRITE IN THIS AREA

SERIAL

KP's transparency journey (circa 2011)

Audience	Past	Present	Future Opportunity
Patient-Practitioner Communications	• Communicating Unanticipated Adverse Outcomes (CUAO) • Informed Consent	• kp.org (e.g., Your Meds, Your Test Results)	• Shared decision making (e.g., preference-sensitive care) • CUAO-RNs • Patient/family centered care • Patients/family members in RCAs
Organization-Member Communications	• Focus groups • PS-related brochures, posters • Safety/Quality-related information in HealthWise	• Members on some committees/workgroups • Practitioner-level information shared within departments • Storytelling to small groups/audiences	• Practitioner-level performance data widely available • Member representation on NQC • Wide scale adoption of Patient Advisory Council • More relevant sales/marketing data
Organization-Staff Communications	• Blinded medical center level data • Quality-related data/information to small, select internal audiences (often blinded)	• Big Q process oriented data • ASPIRE • Unblinded medical center level data shared with small audiences	• Big Q outcomes oriented data • Near real-time sharing of event-related information (e.g., "days since last…") • Names/faces on statistics
Organization-Public Communications	• Well controlled, rehearsed stories • Primitive public Website	• Large national/international conferences • Enhanced public Web site • Some publications	• TJC (unedited) reports • Expanded info. on public Web site • Broader penetration in periodicals/peer-reviewed journals • Cost data
Organization-Employer/Purchaser Communications	• Regional HEDIS performance (not employer specific) • Unique (to KP) utilization reports • Unique (to KP) financial data at time of renewal	• Employer-specific prevention, & chronic care HEDIS, plus maternity and expense reports (PIH) • Industry standard utilization (PUR) • Employee use of kp.org • Ad hoc custom reporting	• Augmented cost reports • Employee productivity gains based on improved health • Validated KP data via 3rd parties (including self-funded employers and industry warehouses (Ingenix) • Employer "Panel" Management access

Education and Training

- IHI Patient Safety Executive course
- KP Patient Safety University
- KP Performance Improvement Institute

Accountable Practices

- Accountability can not exist without proper accounting practices, in other words absence of accounting means absence of accountability. ...
- Accountable Practices:
  - Front Line
  - Middle Management
  - Executives

Accountable Practices for the Front Line

- Briefing and Debriefing
- Huddles
- Stop the line
- Critical Language (“Safety Check”, “Hand”)
- Bedside Handoff
- Multidisciplinary rounds
- Visual Boards
- Vital Behaviors

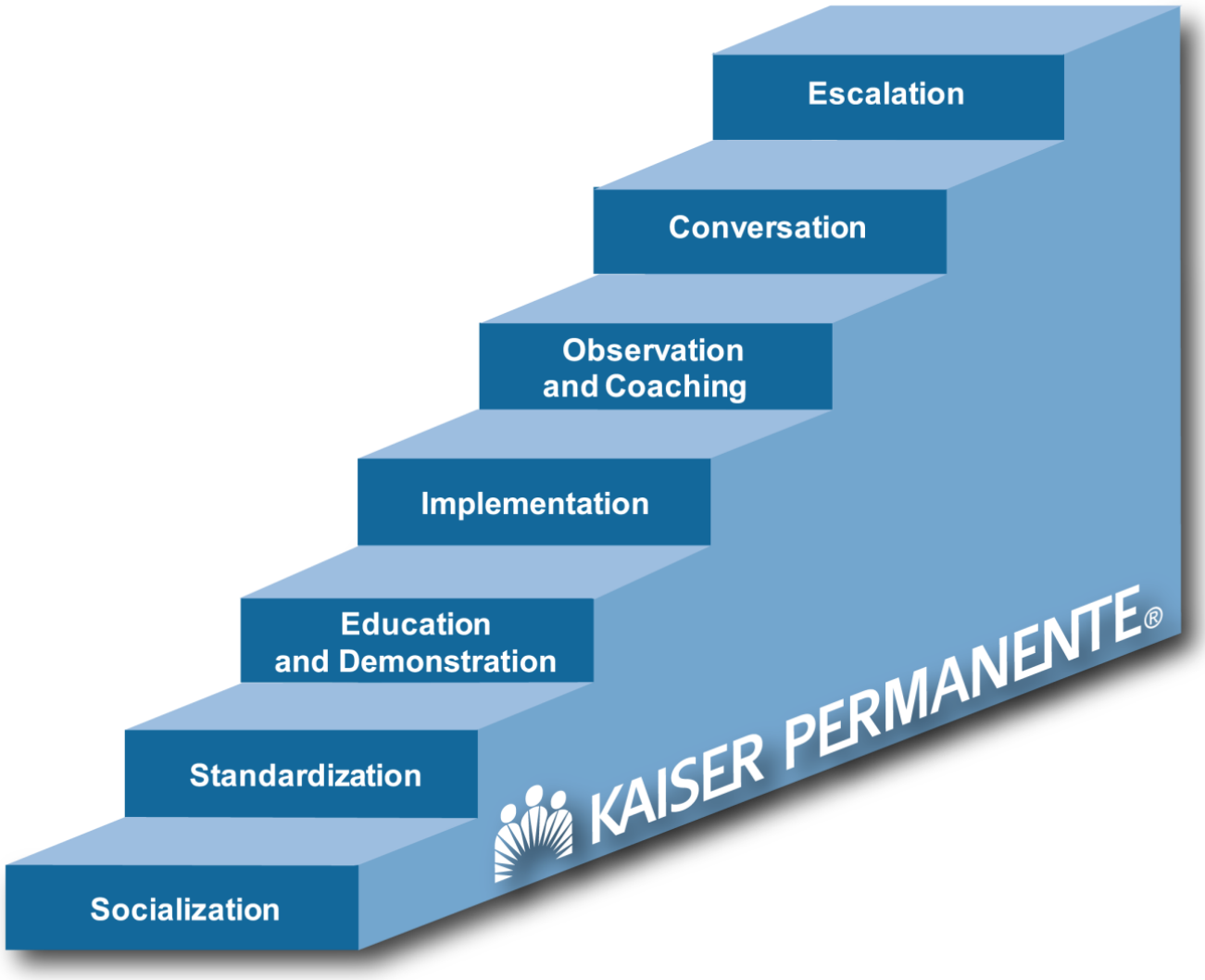
Accountable Practices for Middle Management

- I ensure the appropriate selection, orientation, and ongoing training/education of staff
- I create and sustain a climate of psychological safety
- I ensure workflows are correct, intelligible, and workable
- I provide staff the resources to do their job safely
- I address at-risk behaviors and conditions before they cause harm
- I monitor outcomes and take appropriate action to ensure patient safety
- I maintain a fair and just culture
- I model the safety enhancing behaviors I ask of my staff (next slide)

Accountable Practices for Executives

- Refer to “Not on My Watch”

Hardwiring Hard Stuff



Patient and Family Centered Care (PFCC): A Value to Guide Individual, Team, and Organizational Accountability

Principles	Aim	Activities
Dignity and Respect	We partner with patients & their families, and we are committed to excellent & compassionate care to every patient, every time	Policy Making
Information Sharing		Care Planning and Shared Decision Making
Participation		Patient Safety and Care Experience
Collaboration		Performance Improvement

Upcoming Collaborative Events

- **Webinar**
  - June 17: 12-1pm
- **In-person Capstone Event**
  - July 31: 10am-2pm at the Gordon and Betty Moore Foundation

Registration and event details coming soon!