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
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.

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 MAIR (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
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 System

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

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

**Reckless behavior**
- A conscious disregard of substantial and unjustified risk

- **Console**
- **Coach**
- **Discipline**
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.
Interested in sharing A Fair and 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:
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.
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

**STEP 1**
- Were the actions as intended?
  - yes
  - no → **STEP 2**

**STEP 2**
- Substance Use Or Abuse?
  - no → **STEP 3**
  - yes → Manager Action: Refer to Employee Health

**STEP 3**
- Were the consequences as intended?
  - yes
  - no → **STEP 4**

**STEP 4**
- Deficiencies in training and selection, or inexperienced?
  - no
  - yes → History of unsafe acts?
    - yes → System induced human error
    - no → System induced human error in need of investigation

**STEP 5**
- History of unsafe acts?
  - no
  - yes → System induced human error
    - undefined action needed

- Malevolent, Sabotage, Damage, fraud, etc.

- Reckless Behavior
  - Discipline
  - At Risk Behavior
  - Coach
  - Human Error Console

*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)
## KP’s transparency journey (circa 2011)

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<thead>
<tr>
<th>Audience</th>
<th>Past</th>
<th>Present</th>
<th>Future Opportunity</th>
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| **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

1. Socialization
2. Standardization
3. Education and Demonstration
4. Implementation
5. Observation and Coaching
6. Conversation
7. Escalation
Patient and Family Centered Care (PFCC): A Value to Guide Individual, Team, and Organizational Accountability

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<th>Aim</th>
<th>Activities</th>
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<td>Dignity and Respect</td>
<td>We partner with patients &amp; their families, and we are committed to excellent &amp; compassionate care to every patient, every time</td>
<td>Policy Making</td>
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<td>Information Sharing</td>
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<td>Care Planning and Shared Decision Making</td>
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<td>Collaboration</td>
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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!*