

BALANCING ACCOUNTABILITY AND QUALITY IMPROVEMENT

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Balancing Accountability and Quality Improvement

Objectives:

- **An introduction to**
 - Accountability
 - Quality Improvement
 - Discipline
- **Quality as a result of being aware**
- **Expected behaviors**
- **Just Culture**
- **Case studies/discussion**

DEFINITIONS

Accountability: The obligation of an individual to account for his/her activities, accept responsibility for them, and to disclose the results in a transparent manner

Quality Improvement: Quality Improvement is a formal approach to the analysis of performance and systematic efforts to improve it



AN INTRODUCTION TO DISCIPLINE

“There are activities in which the degree of professional skill which must be required is so high, and the potential consequences of the smallest departure from that high standard are so serious, that one failure to perform in accordance with those standards is enough to justify dismissal.”



**Lord Denning
English Judge**



AN INTRODUCTION TO DISCIPLINE

“People make errors, which lead to accidents. Accidents lead to deaths. The standard solution is to blame the people involved. If we find out who made the errors and punish them, we solve the problem, right? Wrong. The problem is seldom the fault of an individual; it is the fault of the system. Change the people without changing the system and the problems will continue.”

**Don Norman
Apple Fellow**



AN INTRODUCTION TO DISCIPLINE

The single greatest impediment to error prevention in the medical industry is
“that we punish people for
making mistakes.”

Dr. Lucian Leape
**Professor, Harvard School of Public
Health**



QUALITY AS A RESULT OF BEING AWARE

Quality in higher education is a very broad concept.

The multi-dimensional, multi-level and dynamic nature of this concept consists of many aspects, i.e. the contextual settings of an educational model, an institutional strategy, and the specific standards within a given system, program or discipline

(Vlăsceanu, L., Grünberg, L., Pârlea, D.)



QUALITY AS A RESULT OF BEING AWARE

Spreading awareness of the requirements is the first and necessary step to see a horizon of opportunities for quality improvement

There is a need to be knowledgeable of the specific requirements (accreditation standards; Joint Commission, ISO 9001, ..)



THE BEHAVIORS WE CAN EXPECT

Human error - inadvertent action; inadvertently doing other than what should have been done; slip, lapse, mistake.

At-risk behavior - behavior that increases risk where risk is not recognized, or is mistakenly believed to be justified.

Reckless behavior - behavioral choice to consciously disregard a substantial and unjustifiable risk.



ACCOUNTABILITY FOR OUR BEHAVIORAL CHOICES

Human Error

Product of our current system design

Manage through changes in:

- Processes
- Procedures
- Training
- Design
- Environment

Console

At-Risk Behavior

Unintentional Risk-Taking

Manage through:

- Removing incentives for at-risk behaviors
- Creating incentives for healthy behaviors
- Increasing situational awareness

Coach

Reckless Behavior

Intentional Risk-Taking

Manage through:

- Remedial action
- Disciplinary action

Punish

THE TENSION

For Quality Improvement to take place, we must make better use of minor human error events

The threat of disciplinary action is a major obstacle to event reporting and investigation

The role of disciplinary action must be addressed



WE NEED.....

A common understanding about how to treat people
when things happen

A culture that truly supports learning



JUST CULTURE

Safety supportive system of **shared accountability** where healthcare institutions are **accountable for the systems they have designed and for supporting the safe choices** of patients, visitors and staff.


JUST CULTURE

A Set of Beliefs

- A recognition that professionals will make mistakes
- A recognition that even professionals will develop unhealthy norms
- A fierce intolerance for reckless conduct

JUST CULTURE

A Set of Duties

- To raise your hand and say “I’ve made a mistake”
 - To raise your hand when you see risk
 - To resist the growth of at-risk behavior
 - To participate in the learning culture
 - To absolutely avoid reckless conduct
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EXAMPLES OF REPORTABLE EVENTS

- **Adverse Drug Events**
 - Ordering error
 - Dispensing error
 - Administration error
- Misidentification
- Patient Falls
- Pressure ulcers
- Assault

CASE DISCUSSION

Disclaimer

- If you or anyone you know were involved in any of these safety reports, please realize that they are discussed for educational purposes only.
- All patient & health professional information has been omitted to ensure confidentiality.

CASE DISCUSSION

Leukemic patient admitted to receive intrathecal Methotrexate and IM L-Asparaginase. The specialized physician and the patient's nurse prepared the patient for the procedure. At the end of the procedure the physician noticed that the medication given was the L-Asparaginase and not Methotrexate. The patient was transferred to Neuro ICU for 24 hour monitoring.

A complete study of the whole process of chemotherapy administration process was done and gaps were identified. A meeting was scheduled with all concerned disciplines and we came up with several improvement interventions and processes were changed

[..\Chemo RCA.docx](#)

CASE DISCUSSION

8 months Baby admitted to a pediatric unit to perform cardiac catheterization under general anesthesia in cardiac lab.. The patient was sent back to the unit without informing nurse in charge.

After half an hour, the mother called the nurse that the baby was bleeding from the catheterization site.

A multidisciplinary meeting was conducted with all the teams, a standard process was formulated and followed by all concerned.



CASE DISCUSSION

Patient is a 9 year old case of VW deficiency presented with epistaxis to ED on 14-7-2011. She was ordered for Haemate 500 P.

- MD wrote order for Haemate 500 P 1200 IU IVP over 5 minutes, (40 IU per kg)”
- Pharmacy dispensed 3 vials of Haemate 500 P
- RN administered Haemate 1200 units (2.4 vials)
- *NOTE: Haemate 500 P vial has two active ingredients: Factor VIII 500 int'l units & VWF 1200 int'l units.*

Nurse discovered the error on the next day: patient was ordered for 1200 units of VWF, however received 2880 units of VW

[..\HAEMATE 500 P flyer.ppt](#)

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