Managing Risk: Systems Approach Versus Personal Responsibility for Hospital Incidents

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As hospitals grapple with the intense scrutiny of medical errors, administrators may find themselves in the midst of conflicting approaches to improving overall patient safety. One approach to addressing incidents that have been caused by individual practitioners is to consider weaknesses in the system of care at multiple levels that may have enabled an incident to occur. An alternative approach is to hold the individuals responsible for their performance errors and to impose penalties that have specific consequences for those individuals. These two approaches, though not mutually exclusive, can produce conflict among staff.

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Following the Institute of Medicine (IOM) report of 2000[1] there have been numerous calls for increased efforts to detect and report adverse events and to develop strategies for the prevention of medical errors.[2,3] The Joint Commission on Accreditation of Healthcare Organizations [JCAHO] has placed considerable emphasis on promoting patient safety through a variety of mechanisms, including the reporting and analysis of "sentinel events" that can lead to modifications and improvements in policy and practice within health care settings.[4] The basic premise underlying the JCAHO mandate and other national safety initiatives, elucidated by Leape[5] in 1994, is that, to "do no harm," we must apply the same principles learned from the aviation and other high-risk industries to seek methods to detect and learn from our mistakes. Medical errors can be viewed as inevitable yet not acceptable, and we can continuously strive to reduce their frequency and impact by acknowledging their occurrence and developing new approaches to familiar practices.

Leape and others[5–7] have conceptualized errors as system flaws, not character flaws, and advocate continuous quality improvement, in which the reporting of errors is the first step along a constructive process toward understanding what factors within a system enabled an error to take place. This systems approach is gaining ground, and many hospital administrators are becoming well versed in its theory and practice. To promote a "culture of safety," the leadership of an organization promulgates an atmosphere in which the reporting of errors is welcomed, so that others may benefit from knowledge of the situation and can develop strategies based on the data.[8,9] A major element of this framework is a non-punitive stance toward the individual who reports or who was involved in an incident. In a "just culture,"[10] an organization lets its employees know that they will not be disciplined for making mistakes and that the leaders value the importance of learning from mishaps and seek to improve the system that allowed them to occur.

But where do personal responsibility and individual consequences fit in? The IOM report and JCAHO have advocated changes within the legal system to enhance protections for organizations and individuals to increase the rates of disclosure of errors. The Patient Safety and Quality Improvement Act of 2005, signed into Federal law in August 2005,[11] designates patient safety data given to qualified patient safety organizations (certified by the Secretary of Health and Human Services) as privileged and confidential. Although these efforts provide some protection, the national debate on patient safety has led to calls for increased accountability and public disclosure about "performance," including adverse out-

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comes. It is also clear that some errors may be qualitatively different from "honest mistakes," and that an organization may have to respond to the actions of an individual practitioner with disciplinary measures.

In his primer, *Patient Safety and the "Just Culture,"* Marx[10] acknowledges that, while a non-punitive work environment is essential, certain types of behavior are not acceptable and warrant specific sanctions. He defines the legal and organizational concepts of human error, negligent conduct, reckless conduct, and intentional rule violations and develops a matrix of culpability based on these constructs plus the level of risk involved in an incident. His promotion of a non-punitive corporate philosophy does not excuse individuals who knowingly disregard safe practices or policies in high-risk situations, and he offers a model disciplinary policy that balances "the need to learn from our mistakes and the need to take disciplinary action" (Ref. 10, p 3).

Given the importance of analyzing the systems lapses that contributed to the occurrence of a serious incident and yet holding individuals accountable for serious infractions, how does an organization draw the line and determine where a significant error lies along the spectrum? The following is a summary of an incident and investigation that brought these matters sharply into focus.

The IRB at Yale determined that the material presented in this article does not meet criteria for Human Subjects Research and is exempt from review and approval.

Case Example

Within a period of two hours on the evening shift in an inpatient psychiatric unit, two patients who were on one-to-one observation harmed themselves. Although neither incident resulted in serious injury, their confluence and timing raised serious concerns within the clinical administration. Senior managers of the freestanding psychiatric hospital decided to perform a Root Cause Analysis, the strategy that JCAHO prescribes to investigate a serious event.[12] Although the incidents did not meet criteria for a "sentinel event" (i.e., a suicide attempt requiring inpatient medical treatment), the administration considered them each to be a "near miss," and worthy of intensive review.

Patient A was a young woman who asked the staff member performing her one-to-one observation for a razor to shave her legs. The staff member asked a senior nurse if that was permitted, and the nurse told the junior staff member that she could give the patient a razor if she "watched her carefully." The senior nurse offered no further clarification regarding this directive. The patient managed to hurt herself intentionally with the razor while being observed closely.

Patient B was a young man who tied shoelaces around his neck while in the bathroom. The staff member who was assigned to remain in close proximity to the patient, keeping him within eyesight, had not kept the bathroom door ajar when the act occurred.

Two investigative processes took place in parallel over the course of the week following the two incidents. For the purposes of this account, only the incident involving Patient A will be described in detail. The Root Cause Analysis examined several possible contributing factors, including the recent expansion of the census of the unit, the hiring of new staff, the lack of knowledge and consistent adherence to the policy on providing certain items to patients who are on sharps precautions, the presence on the unit of certain types of razors, and the lack of communication among clinical staff regarding Patient A's risk for self-harm. The senior nurse's advice to the newer staff member was seen as a function of poor clinical judgment, and the failsafe mechanisms that might have prevented the incident (e.g., conferring with the on-call nursing or medical leadership of the unit) were either not utilized or were not in place. The unit's medical leadership valued the senior nurse, and the clinical administrators involved in the review did not develop the perspective that she or the junior staff member were to be "blamed" for the incident. Part of the plan to prevent other such incidents involved specific efforts to improve communication among the various staff levels of the unit regarding policies and clinical data.

In parallel to this review and plan for improvement in the system of care, the hospital's human resources department conducted its own personnel investigation, following a more traditional model. The investigation was initiated by the director of nursing when she learned that a patient had harmed herself while on one-to-one observation, possibly because of a breach in professional behavior by nursing staff. The investigation focused on the senior nurse who sanctioned the use of the razor. The unit's policy included a statement that no one on sharps or belts

precautions was to be given one of those items without a physician's order, and the senior nurse's action was considered to be in flagrant disregard of that policy. The director of human resources and the director of nursing recommended serious disciplinary action for this work rule violation, to emphasize their commitment to the enhancement of patient safety.

A high degree of conflict erupted within the senior leadership of the institution regarding these disparate interpretations of what might have led to the incidents and what actions were warranted. After a lengthy process, the final resolution was to impose much less serious sanctions on the individual staff member and to implement the recommended systems changes. Using Marx's points of reference, the perspective that was developed was that the nurse's behavior was negligent, in that there was "failure to exercise expected care," and she "should have been aware of substantial and unjustifiable risk" (Ref. 10, p 11), but there was no indication of reckless disregard for the clinical risk or for the unit's policy.

Discussion

This case illustrates the culture clash that can emerge as a health care institution considers its approaches to the contribution of staff behavior to patient safety. The theoretical basis for continuous quality improvement and its application to medical errors and patient safety were appreciated and applied in the understanding of this case by medical staff and other clinical leaders. The emphasis on holding individuals responsible for their performance, however, is another key element in how organizations continue to function. Indeed, there may be situations in which personnel and/or legal sanctions are entirely warranted. The adoption of a systems approach to the prevention and remediation of errors and efforts to enhance personal accountability are not mutually exclusive, but clinical and administrative leaders must recognize potential conflict and draw an explicit line as to where the emphasis is placed.

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