High Reliability & Healthcare
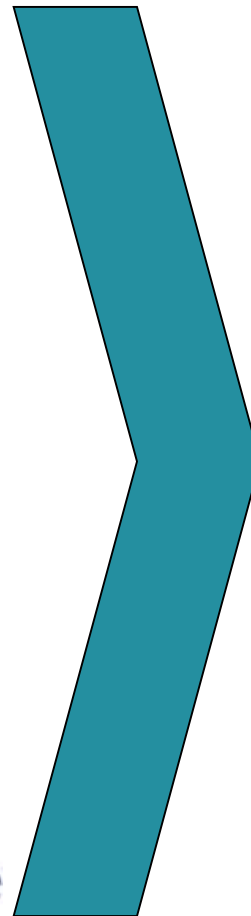
7/23/2018

Four Entities – One Vision

The Joint Commission

Joint Commission International

Joint Commission Resources

Joint Commission Center for Transforming Healthcare

All people always experience the SAFEST, HIGHEST QUALITY, BEST-VALUE health care across all settings.

2

Unique Scope Of Operations
Comprehensive Accreditation / Certification Services

Disease-Specific Care Certification and Health Care Staffing Services Certificiation

HOSPITALS → PRIMARY CARE HOME

AMBULATORY CARE → PRIMARY CARE HOME

LABORATORIES → PATIENT BLOOD MANAGEMENT

HOME CARE → COMMUNITY-BASED PALLITIVE CARE

NURSING CARE CENTERS → PATIENT ACUTE CARE / MEMORY CARE

BEHAVIORAL HEALTH CARE → BEHAVIORAL HEALTH HOME

PATIENT

Integrated Care Certification
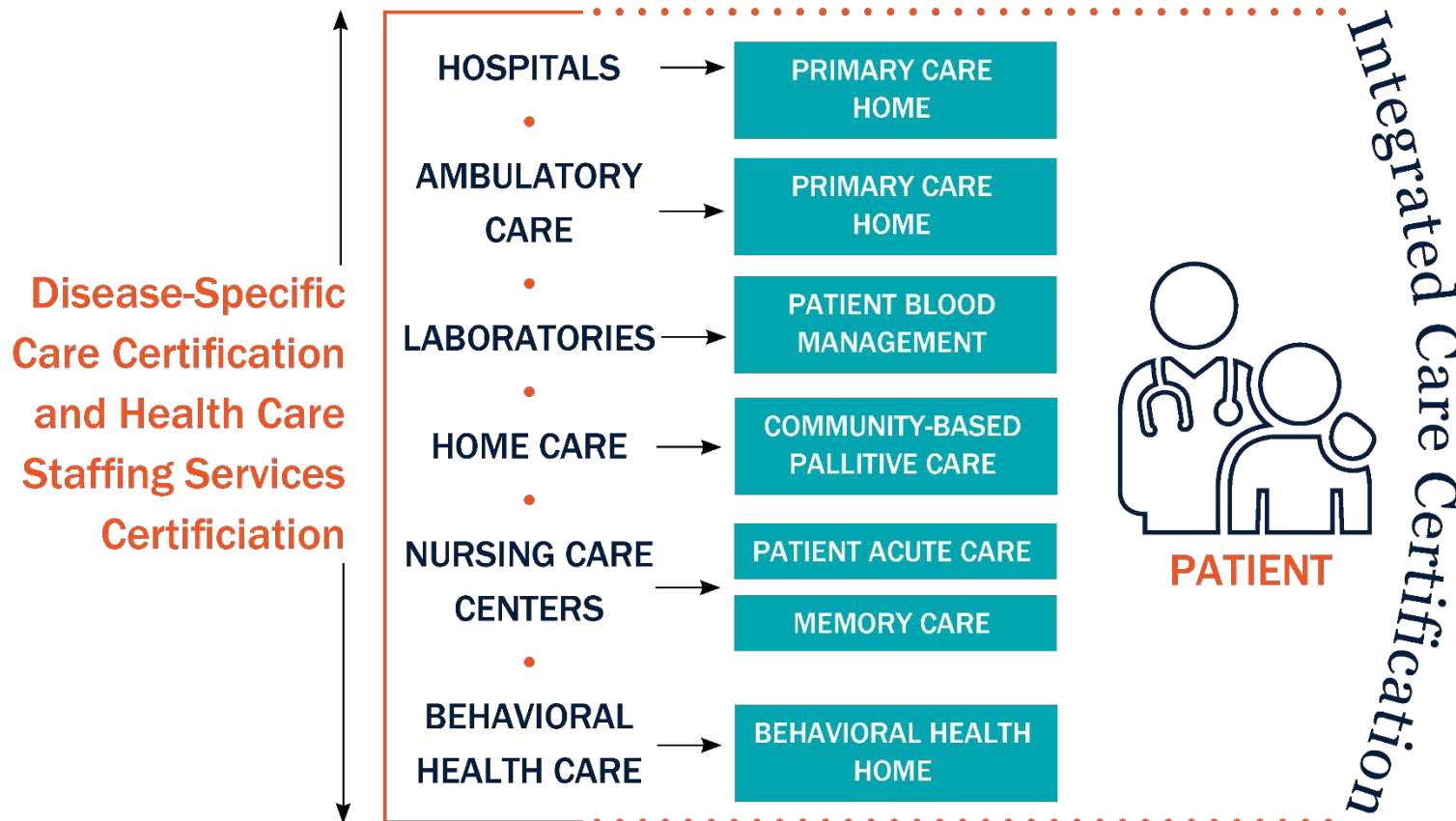
Unique Scope Of Operations
Comprehensive Support Services

Joint Commission Center for Transforming Healthcare

ACCREDITATION & REGULATORY CONSULTING SERVICES

- Continuous Service Readiness (CSR)
- Accreditation and Certification Preparation
- Centers for Medicare and Medicaid Services (CMS)
- Interim Quality Services

PERFORMANCE IMPROVEMENT CONSULTING SERVICES

- EHR
- Environment of Care®
- Infection Prevention and Control
- Multidrug-Resistant Organisms (MDRO)
- Medication Safety
- Medication Reconciliation
- Reducing Readmissions
- Safe Health Design
- Industry Services

SOFTWARE

- Accreditation Manager Plus®
- Tracers with AMP®
- E-dition®
- ECM Plus®
- CMSAccess®

PUBLICATIONS

- Books
- eBooks
- Manuals
- Periodicals

EDUCATION

- Conferences
- Seminars
- Custom Education
- Webinars
- JCR Quality and Safety Network (JCRQSN)

CJCP CERTIFICATION

The highest level of accreditation knowledge and achievement in related patient safety and quality issues, developed and endorsed by The Joint Commission and Joint Commission Resources

Unique Approach To Zero
A Healthcare Framework For High Reliability

High Reliability & Health Care

Objectives

– Discuss the principles of high reliability organizations and what makes health care different

– Describe the High Reliability Health Care Maturity model and its specific application

– Discuss the importance of performance improvement capacity in healthcare and identify the robust tool set that provides the most benefit.

...ission Center
...ming Healthcare

Find a Job | M&S Wine | Our Papers | Feedback   Friday, May 11 2012 6PM 19°C ☀ 9PM 20°C ☀ 5-Day Forecast

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'You're taking out wrong kidney, surgeon was told'

by CLARE KITCHEN, Daily Mail

💬 Comments (0) | 🔗 Share

A surgeon accused of killing a patient by taking out the wrong kidney was warned he was making a mistake by a medical student watching the operation, a court heard yesterday.

Dr Mahesh Goel dismissed the concerns of student Victoria Fern and pressed on with the surgery, it was said.

Goel and consultant urologist John Roberts are accused of manslaughter over the 'appalling error' which left 70-year-old Graham Reeves with one diseased kidney.

The Korean War veteran died five weeks after the botched operation.

Surgeon accused of removing kidney from the wrong patient

Roberts, 59, and Goel, 39, had shown a level of care far below that which is expected of competent surgeons, prosecutor Leighton Davies QC said.

'It was a drastic surgical error described by Mr Roberts himself in the aftermath as the worst thing he had done in his life,' said Mr Davies. 'He says it was an appalling error.'

POSTED 7:05 AM, AUGUST 11, 2016, BY CNN WIRE

Mr Reeves, who was single, was due to have his damaged right kidney removed. But the surgeons removed his left kidney and before the mistake was realised it was put in a jar of acidic sterilising agent.

WORCESTER, Mass. – Massachusetts health authorities are investigating an allegation that a surgeon removed a kidney from the wrong patient.

'The right kidney was diseased for years and non-functioning,' Mr Davies told Cardiff Crown Court.

'The operation played a significant part in causing his death. It deserves to be condemned as gross negligence and therefore a crime.'

Aug 12, 2013

SOUTHERN
Daily Echo

JAMA Internal Medicine | Review | LESS IS MORE
2017 Update on Medical Overuse
A Systematic Review

12th October

Southern Health prosecuted after patient falls from roof of mental health facility

— 8

Evolution of Healthcare

Current State of Quality

- Routine safety processes fail routinely
  - Hand hygiene
  - Medication administration
  - Patient identification
  - Communication in transitions of care

- Uncommon, preventable AEs
  - Wrong surgery, retained foreign objects
  - Fires in ORs
  - Infant abductions, inpatient suicides

Current State - Improvement

- We have made some progress
  - Project to project work → "project fatigue"
  - Satisfied with modest improvement

- Current approach is not good enough
  - Improvement difficult to sustain/spread
  - Getting to zero harm, staying there is very rare

High Reliability offers a different approach

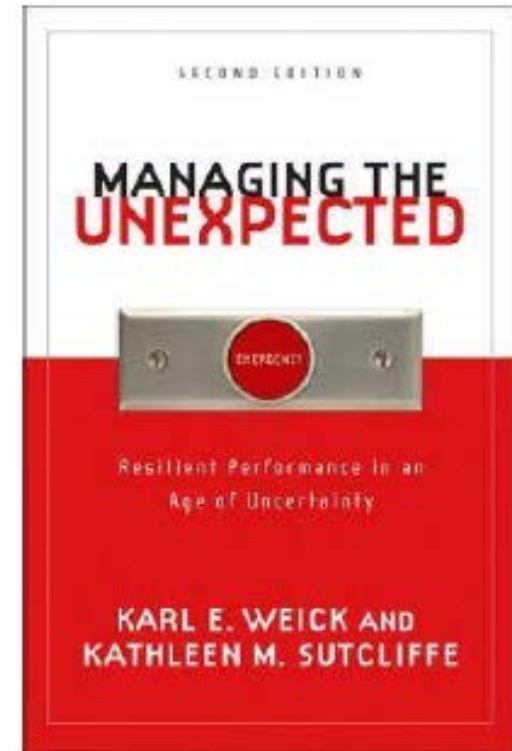# Five Principles of High Reliability Organizations

Joint Commission Center for Transforming Healthcare

Anticipation – "Stay Out of Trouble"

1. *Preoccupation with failure*
2. *Reluctance to simplify*
3. *Sensitivity to operations*

Containment – "Get Out of Trouble"

4. *Commitment to resilience*
5. *Deference to expertise*

Mindful Organizing

High Reliability Organizations' Secret Sauce

- **Nearly error-free performance is a function of mindful-organizing**
  - Set of behavioral and cognitive processes
  - Workers discern latent and manifest threats
  - Actions are swiftly taken to resolve threats

- **Mindful organizing results in**:
  - Lower error rates
  - More reliable service performance
  - Lower turnover

THE MILBANK QUARTERLY

High-Reliability Health Care: Getting There from Here

MARK R. CHASSIN and JEROD M. LOEB

The Joint Commission

Context: Despite serious and widespread efforts to improve the quality of health care, many patients still suffer preventable harm every day. Hospitals find improvement difficult to sustain, and they suffer "project fatigue" because so many problems need attention. No hospitals or health systems have achieved consistent excellence throughout their institutions. High-reliability science is

14

Milbank Q 2013;91(3):459-90

High reliability in healthcare is "maintaining consistently high levels of safety and quality over time and across all health care services and settings"

Chassin & Loeb (2013)

HIGH RELIABILITY MODEL FOR HEALTHCARE

Leadership

Safety Culture

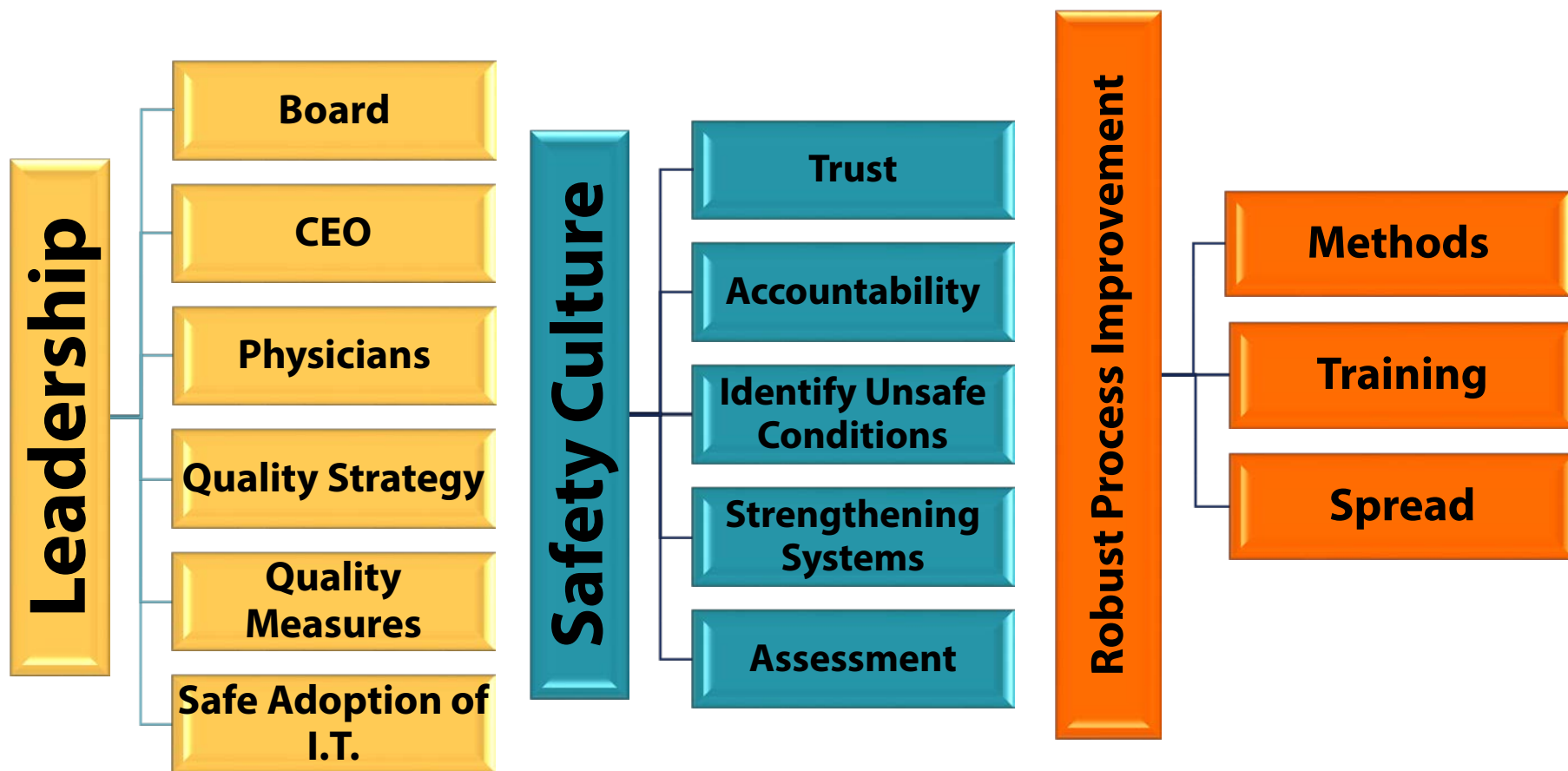**Robust Process Improvement®**

Commitment to zero harm

Empowering staff to speak up

Systematic, data-driven approach to complex problem solving

Chassin MR, Loeb JM. High-Reliability Health Care: Getting There from Here. *Milb* Q 2013;91(3):459-90

AREAS OF PERFORMANCE

Joint Commission Center
for Transforming Healthcare

Leadership
- Board
- CEO
- Physicians
- Quality Strategy
- Quality Measures
- Safe Adoption of I.T.

Safety Culture
- Trust
- Accountability
- Identify Unsafe Conditions
- Strengthening Systems
- Assessment

Robust Process Improvement
- Methods
- Training
- Spread

Stages of Maturity: Beginning ➡ Developing ➡ Advancing ➡ Approaching

Leadership Elements

Leadership

Element	Description
Board	Commitment to High Reliability
CEO	Aims for the goal of zero harm
Physicians	Routinely champion PI initiatives
Quality Strategy	Elevated to highest strategic goal
Quality Measures	Data transparency
Safe Adoption of I.T.	Coordinated and integrated adoption

Engaging Leadership

- High Reliability efforts unlikely to make headway without board engagement and aligned and supportive senior leadership

- Make the case for high reliability

  - Not "another project"

- Enlist support from key leaders

- Illustrate the business case

Physician Engagement

- Crucial to project and program success

- Sponsor & Champion Roles

- Provide training

Quality Strategy & Measurement

- **What is the organization's approach to measuring quality and safety**?
  - Measurement goes beyond regulatory requirements

- **Transparency** of Information
  - Who can access & how?

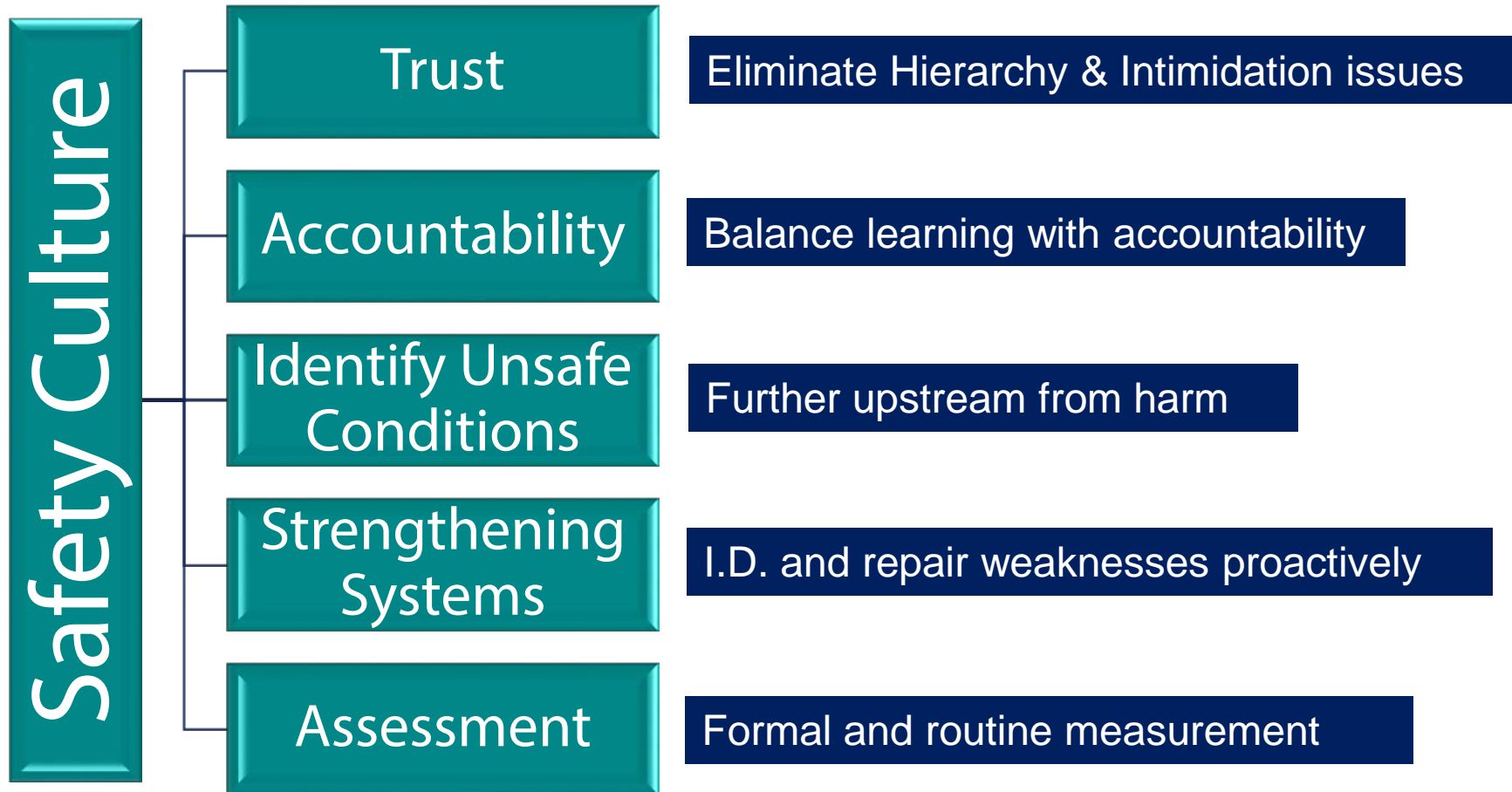- Align **incentive systems** based on results

Safe Adoption of IT

– Support from IT for quality/safety improvement programs

– IT solutions are integral to sustained improvement

– Commitment to safety

Business Case for Quality

- Opportunity – system failures to drive quality strategy
- Reducing defects in care benefits all
- Organizational Interests
  - Patient – trusting relationships
  - Caregiver – engagement
  - Reputation
  - Margin for mission
    - Variation/Waste/Defect ROI
    - Diffusion ROI

Swensen, S et al. The Business Case for Health-Care Quality Improvement. *J Patient Saf 2013;* 9(1): 44-52.

Safety Culture Elements

Safety Culture

Trust	Eliminate Hierarchy & Intimidation issues
Accountability	Balance learning with accountability
Identify Unsafe Conditions	Further upstream from harm
Strengthening Systems	I.D. and repair weaknesses proactively
Assessment	Formal and routine measurement

High Reliability Organizations' Secret Sauce

- **Nearly error-free performance is a function of mindful-organizing**

  - Set of behavioral and cognitive process

  - Workers discern latent and manifest threats

  - Actions are swiftly taken to resolve threats

- **Mindful organizing results in**:

  - Lower error rates

  - More reliable service performance

  - Lower turnover

Drive out fear and create trust

- *W. Edward Deming*

Evolution of Safety Culture

Joint Commission Center for Transforming Healthcare

- Today, we mostly react to adverse events

- <u>Unsafe conditions</u> are further upstream from harm than close calls

- <u>Close calls</u> are "free lessons" that can lead to risk reduction—if they are recognized, reported and acted upon

- Ultimately, proactive, routine assessment of safety systems to identify and repair weaknesses gets closer to high reliability

Safety Culture Challenges

- Aim is not a "blame-free" culture
- A true safety culture balances *learning* with *accountability*
- Must separate *blameless* errors (for learning) from *blameworthy* ones (for discipline, equitably applied)
- Assess errors and patterns uniformly
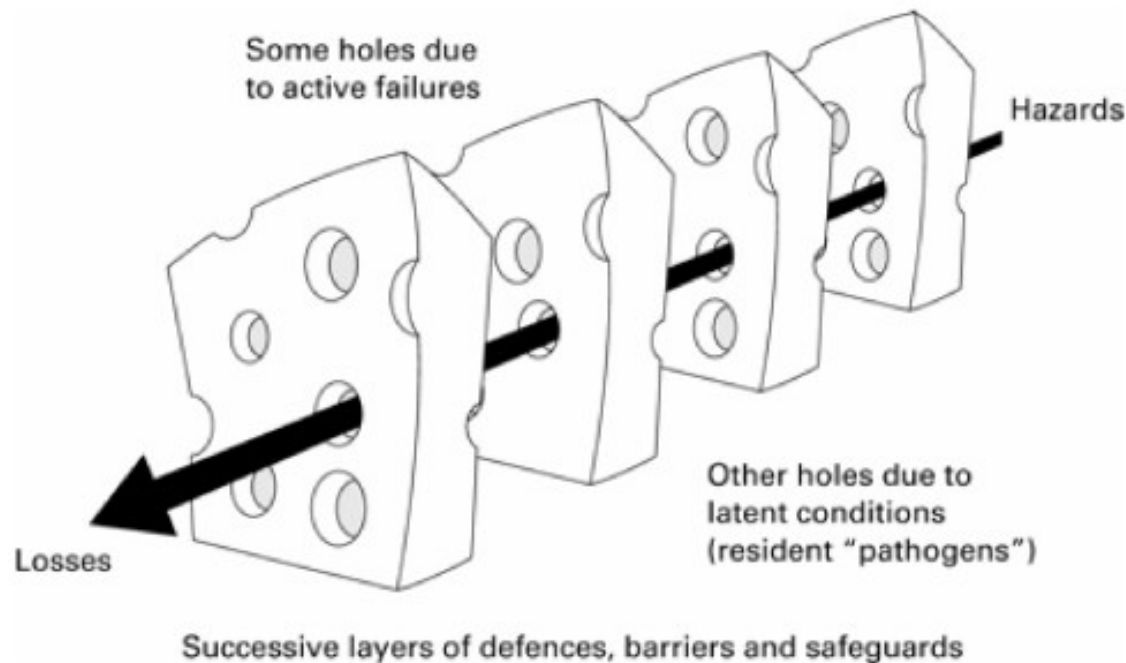- Eliminate intimidating behaviors

Culture of Low Expectations

– **Expectation of failure instead of preoccupation**

- Coding is inaccurate
- Equipment can't be found or is broken
- Work arounds are necessary

– **Simplification results from time pressures**

– **High tolerance for hazard**

– **Variation makes resilience difficult, as does lack of transparency**

– **Hierarchy issues persist**

Identifying Unsafe Conditions

- Unsafe Condition: a situation that could lead to an adverse event

- Unsafe conditions are frequently not noticed or considered "annoyances":

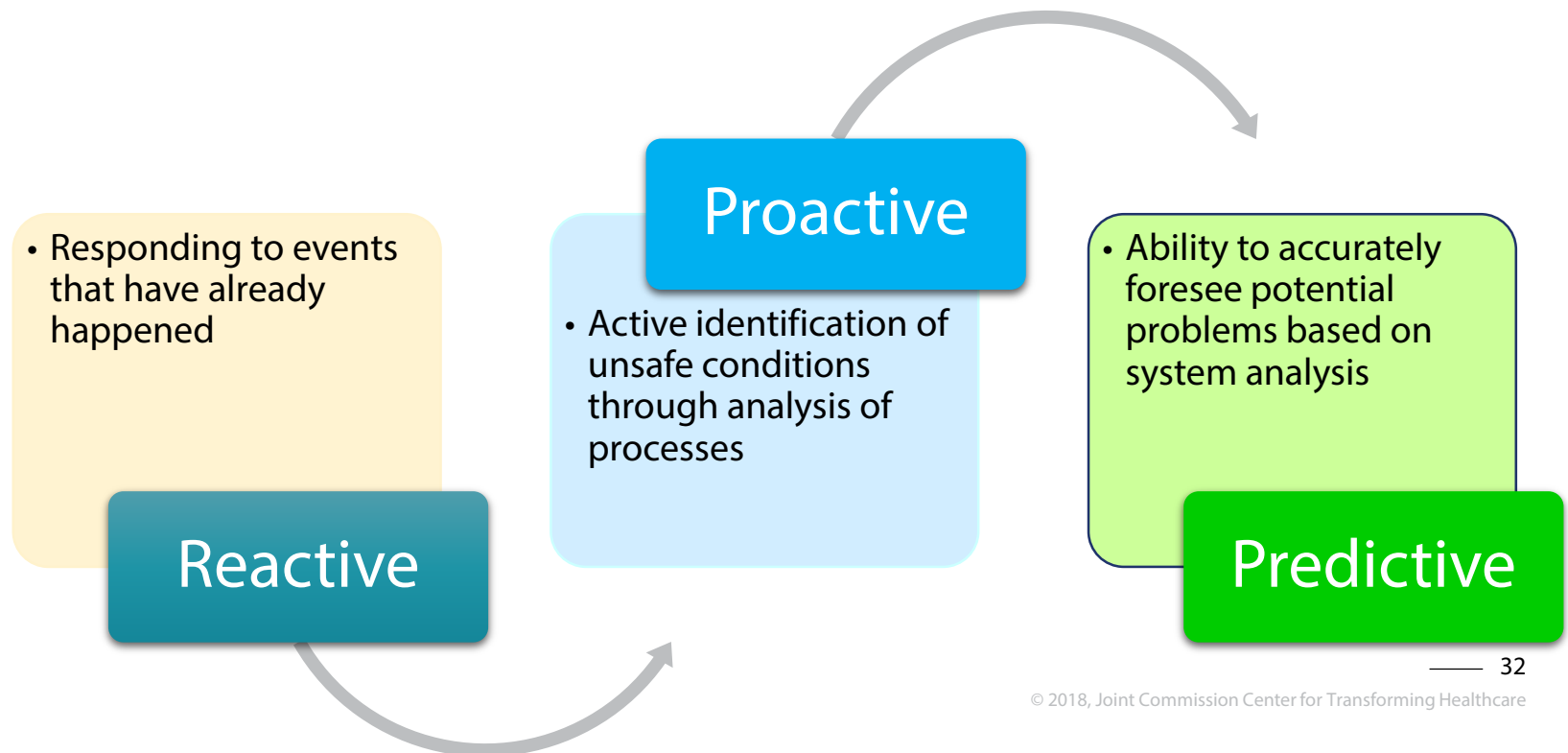 - Nuisance alarms, missing equipment, broken equipment

PHONE IS TEMPORARILY OUT OF SERVICE

EMERGENCY PHONE FIRE ALARM

Identifying Unsafe Conditions

Some holes due to active failures

Hazards

Other holes due to latent conditions (resident "pathogens")

Losses

Successive layers of defences, barriers and safeguards

Reason J. Human error: models and management. BMJ. 2000;320:768–70..

Strengthening Systems

– What efforts are in place to recognize patterns of causal factors across the organization?

– Efforts to catalog and prioritize system weaknesses-- proactively

Reactive
- Responding to events that have already happened

Proactive
- Active identification of unsafe conditions through analysis of processes

Predictive
- Ability to accurately foresee potential problems based on system analysis

The most detrimental error is failure to learn from an error.

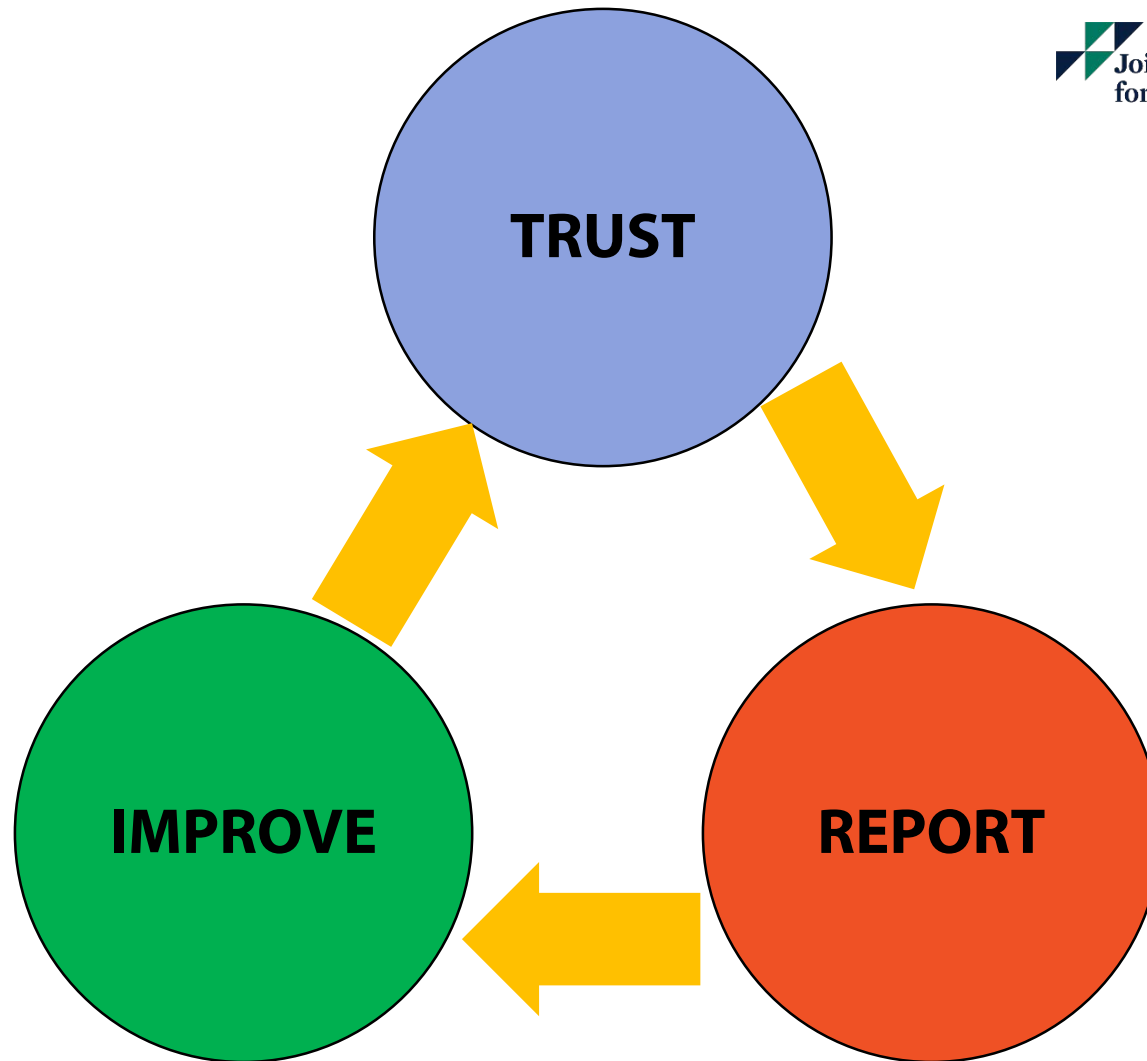~James Reason

Tactics for Assessing Culture

Assessment:

- Frequency and distribution important

- Results used to plan efforts to improve

- Metrics around improvement efforts reported to senior leadership; systematic improvement initiatives are in place

Using Assessment Results

− Leadership mistake:

  • Asking what staff think (i.e. via survey) and then deciding what they said.

− Appreciative inquiry to understand by asking 'why they said what they said'.

− Culture is local—actions need to be as well

BUILDING POSITIVE RELATIONSHIPS AND BETTER ORGANIZATIONS

EDGAR H. SCHEIN

HUMBLE INQUIRY

THE GENTLE ART OF ASKING INSTEAD OF TELLING
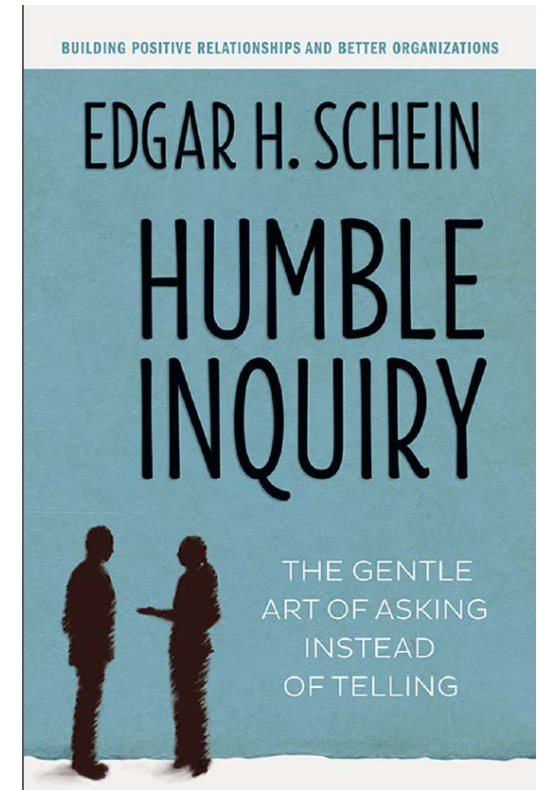
Adapted from Reason J and Hobbs A. Managing Maintenance
Error: A Practical Guide. Ashgate. 2003.

Sentinel Alert Event

A complimentary publication of The Joint Commission
Issue 57, March 1, 2017

The essential role of leadership in developing a safety culture

Published for Joint
Commission-accredited

11 Tenets of a Safety Culture

Definition of Safety Culture

Safety culture is the sum of what an organization is and does in the pursuit of safety. The Patient Safety Systems (PS) chapter of The Joint Commission accreditation manuals defines safety culture as the product of individual and group beliefs, values, attitudes, perceptions, competencies, and patterns of behavior that determine the organization's commitment to quality and patient safety.
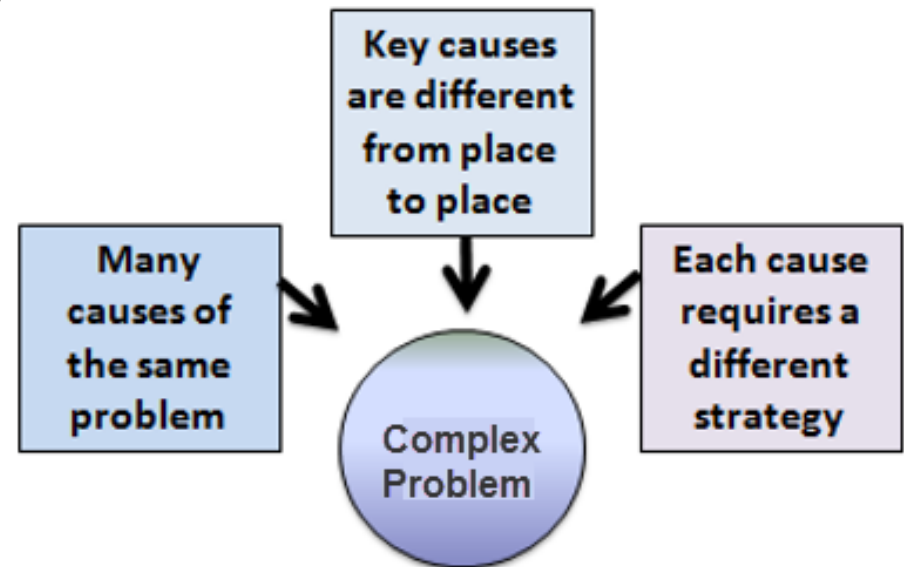
Robust Process Improvement® Elements

Robust Process Improvement

Methods	Lean, Six Sigma, Change Management
Training	Training for all employees
Spread	Widespread adoption

Performance Improvement Capacity

- Two major factors are holding healthcare back:
  - ➤ Between 50% & 75% of improvement efforts fail due to a lack of focus on the people side of change
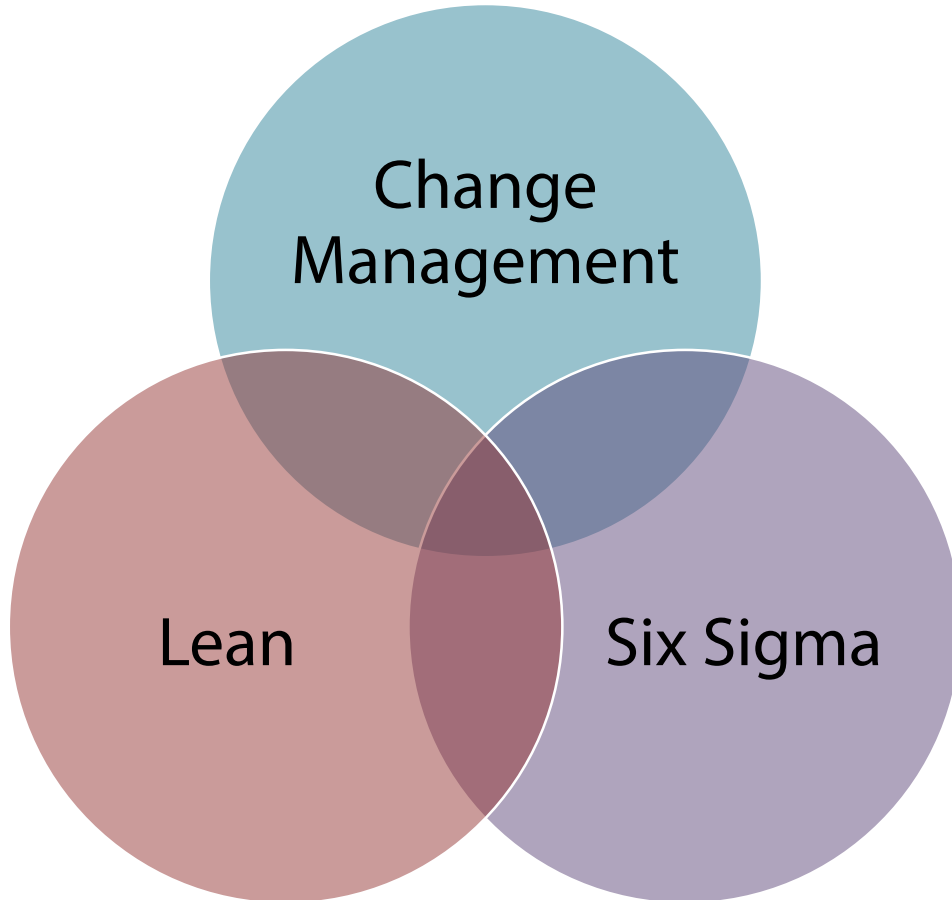
And:

New Generation of Best Practices

Complex processes require RPI to produce solutions that are customized to an organization's most important causes.

Key causes are different from place to place

Many causes of the same problem

Each cause requires a different strategy

Complex Problem

Robust Process Improvement®

RPI® is a blended set of strategies, tools, methods, and training programs—including Lean, Six Sigma, and Change Management—that is used to improve business processes and clinical outcomes.

Lean and Six Sigma

Lean empowers employees to identify and act on opportunities to improve processes

Lean tools increase value by eliminating steps in processes that represent pure waste

Six sigma improves outcomes of processes by identifying and targeting causes of failure

Together they are a systematic, highly effective toolkit for process improvement

⟶ | Lean and six sigma routinely produce 50%+ improvement

More than tools…

- Strategic project selection

- Common language

- Competency-based deployment

- Project management

- Data driven analysis is critical for complex problems

Technical Solution is Not Enough

Lean, six sigma provide technical solutions that can markedly in
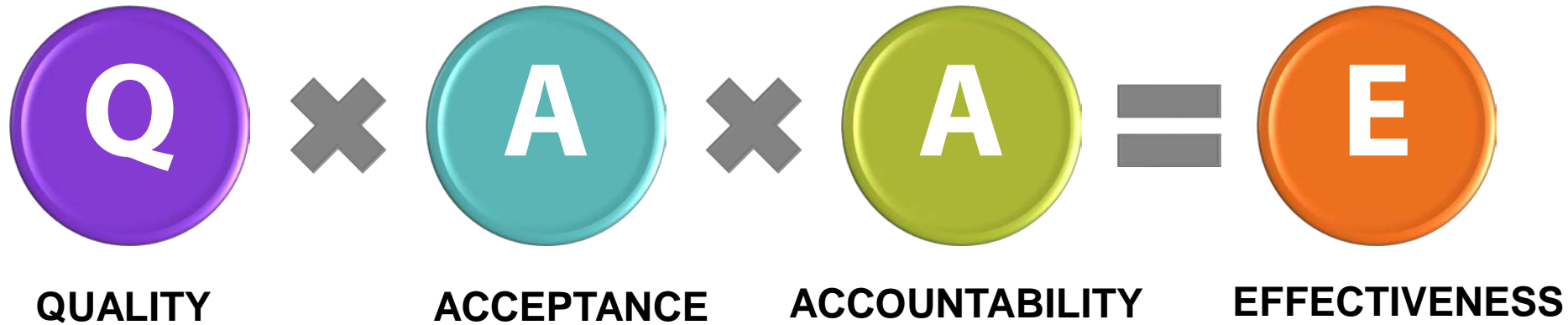
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sustain good solutions

<div style="border: 2px solid orange; text-align: center;">

Change management is the rocket science of improvement

</div>

Change Management:
GE's Formula for Results

$$Q \times A \times A = E$$

QUALITY × **ACCEPTANCE** × **ACCOUNTABILITY** = **EFFECTIVENESS**

Studies show that between 50% and 75% of improvement efforts fail due to a lack of focus on facilitating change.

Adapted from General Electric Co.'s Change Acceleration Process © 2008.

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Facilitating Change™

Plan Your Project

- Assess the Culture
- Define the Change
- Assemble a Strategy
- Engage the Right People
- Brainstorm Barriers to Success
- Build the Need for Change
- Paint a Picture of the Future State

Launch the Initiative

- Align Operations and Infrastructure
- Get the Word Out

Support the Change

- Permeate the Culture
- Monitor Progress
- Sustain the Gains

Inspire People

- Make It Personal
- Solicit Support and Involvement
- Look for Resistance
- Lead Change

Plan Your Project | Inspire People | Launch the Initiative | Support the Change

Facilitating Change

45

Zero Patient Harm Is Achievable

https://vimeo.com/211533916

Some organizations are achieving zero

– Small steps and specific goals:

- CLABSI or CAUTI or HAPI

– Get beyond compliance—it is about behaviors and individual human factors

– Collaboration is the key—focus on safety culture change rather than injury reduction (OUCH Program!)

– Determine your cornerstones: Trust? Transparency? Accountability?

Be Patiently Impatient…

✓ The quest for high reliability takes time—so start now

✓ Culture change can be difficult

✓ High Reliability Organizations value information

✓ Everyone

…feels free to speak up with concerns

…has a low tolerance for hazards

…has conversations about risk and safety

✓ The alternative doesn't bear consideration