Influencing Health Care: Overlapping Strategies

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Vice President & Chief Patient Safety Officer
Joint Commission (JCAHO)

Chief Patient Safety Officer & Co-Director
Joint Commission International Center for Patient Safety

Chicago, USA
Balancing Healthcare

Equity → Cost → Efficiency

Access → Quality

Joint Commission International Center for Patient Safety
-THREE THINGS-
LEFT IN PATIENTS THAT CAN
COST YOUR HOSPITAL MILLIONS

INSTRUMENTS

SPONGES
CMS’ estimates for national healthcare spending calendar years ($ billions)

- **National Health Expenditures**
- **As a % of gross domestic product**

<table>
<thead>
<tr>
<th>Year</th>
<th>Spending ($ billions)</th>
<th>% of GDP</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>2,164</td>
<td>16.5%</td>
</tr>
<tr>
<td>2007</td>
<td>2,320</td>
<td>16.8%</td>
</tr>
<tr>
<td>2008</td>
<td>2,498</td>
<td>17.2%</td>
</tr>
<tr>
<td>2009</td>
<td>2,689</td>
<td>17.6%</td>
</tr>
<tr>
<td>2010</td>
<td>2,879</td>
<td>18%</td>
</tr>
<tr>
<td>2011</td>
<td>3,078</td>
<td>18.3%</td>
</tr>
<tr>
<td>2012</td>
<td>3,298</td>
<td>18.7%</td>
</tr>
<tr>
<td>2013</td>
<td>3,533</td>
<td>19.2%</td>
</tr>
<tr>
<td>2014</td>
<td>3,776</td>
<td>19.6%</td>
</tr>
<tr>
<td>2015</td>
<td>4,032</td>
<td>20%</td>
</tr>
</tbody>
</table>

*Source: CMS, Office of the Actuary*
How does the annual Change per Capita in Health Care Spending compare with the annual Change in Gross Domestic Product?

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits; 2003. Dental work by Arnie Milstein, MD. Note: Data on premium increases reflect the cost of health insurance premiums for a family of four.
VORTEX OF PRESSURES

EDUC’n & TRAINING
- SILO Approach
  - ACGME et al.
  - ACCME et al.
  - Competence

RESEARCH & DEVELOP’l
- NIH Funding
- FDA Processes
- Industry Funds
- Foundation Funds

Military Healthcare

Healthcare
- AHRQ, IHI, Leapfrog...
- IOM & Other Reports
- JCAHO Initiatives
- CMS Fee Structure

EXTERNAL AGENCIES

CLINICAL CARE
- Healthcare & Liability Insurance Confusion
- Technology Access
- Human Resources
- Products vs. Processes

An Incomplete Listing…
“The acute care hospital is the most complex organization to lead and manage.”

- Peter Drucker

- Highly Complex Processes
- Unique Problems & Patient Variability
- Loosely Knit Team System
- Multiple Outcomes Measures
- Incomplete Evidence Base
- Variable Layers of Responsibility
- Unpredictable Workloads & Case Mix
- Work Hours, Fatigue & Variable Employee Support Systems
Aircraft accident rates were extremely high post WWII - 1970’s
Caused accident rates to decline significantly until the mid 1970’s.
Since then, accident rate leveled off
Patient Safety – Where is it?
Institute of Medicine:

“A culture of safety is an integrated pattern of individual and organizational behaviors based on shared beliefs and values that continuously seeks to minimize patient harm that may result from the processes of care delivery”

(Kizer, 1999)
Normalization of Deviance!

(Vaughan)

Failure Levels:

- Patient & families
- Physicians & practice support
- RN, MD & other staff @ HCO
- Communications & systems
- Technology @ HCO
- HCO prevention & responses for errors
- Oversights of staff & hospital
- Oversights of Hospital Assoc’n.
- Accreditation by Joint Commission
- Cultural expectations
Swiss Cheese Model of Adverse Event Causation

Triggers
- Incomplete Procedures
- Mixed Messages
- Production Pressures
- Responsibility Shifting
- Regulatory Narrowness

Defenses
- Inadequate Training

Latent Failures
- Attention Distractions
- Clumsy Technology
- Deferred Maintenance

The World

Institution Organization Profession Team

DEFENSES

Individual Technical

Adverse Event

Adopted from J. Reason
DOMAIN: patient and provider characteristics, etc.

PREVENTION: provision of language services, language training, read back, etc.

CAUSE: staffing, organizational culture, human error, negligence?

TYPE: inaccurate info, assessment and follow-up, misdiagnosis

IMPACT: psychological, physical, etc.

PREVENTION & MITIGATION

(Loeb et al)
A Core Set of Principles for Patient Safety from the experience of other industries and early adopters:

- Standardize
- Simplify processes
- Include patient in design
- Design mechanisms for reporting and learning from errors
- Seek redundancy through use of technology to support clinical decision making
- Avoid reliance on memory
- Use constraints and forcing functions
- Simulate planned and unplanned events for how people interact with each other and technology
- Plan for failure and design for recovery
- Provide access to a core set of integrated clinical information at time and point of decision making
Safety Principles

- Avoid reliance on memory

**MOST EFFECTIVE**

1. Forcing functions
2. Automation, computerization
3. Protocols and preprinted orders
4. Checklists
5. Rules and double-checking
6. Education
7. Information

**LEAST EFFECTIVE**
Diffusion of Innovations

Definitions:

- The process by which an innovation is communicated through certain channels over time among members of a social system.
- It is a special type of communication concerned with the spread of messages that are perceived as new ideas.
How does a Board evaluate their effectiveness?

<table>
<thead>
<tr>
<th>Pathological Culture</th>
<th>Bureaucratic Culture</th>
<th>Generative Culture</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Don’t want to know</td>
<td>• May not find out</td>
<td>• Actively seek</td>
</tr>
<tr>
<td>• Messengers (Whistle blowers) are “shot”</td>
<td>• Messengers are listened to if they arrive</td>
<td>• Messengers are trained and rewarded</td>
</tr>
<tr>
<td>• Failure is punished or concealed</td>
<td>• Failure leads to local repairs</td>
<td>• Failures lead to far-reaching reforms</td>
</tr>
<tr>
<td>• New ideas are actively discouraged</td>
<td>• New ideas often present problems</td>
<td>• New ideas are welcomed</td>
</tr>
</tbody>
</table>

Memorial Health System, Springfield, IL
Teamwork Climate & Annual Nurse Turnover

% reporting positive teamwork climate

High Turnover 16.0%
Mid Turnover 10.8%
Low Turnover 7.9%

RN Teamwork Climate | Staff Physician Teamwork Climate
THERE IS MORE HERE THAN MD & RN INTERACTIONS

ICU Physician and RN Collaboration

RN rates MD
MD rates MD

ICU Physician and RN Teamwork

RN rates ICU Physician
ICU Physician rates RN

90%
54%
How We Learn & Remember…

- 10% of what we read
- 20% of what we hear
- 30% of what we see
- 50% of what we see & hear
- 80% of what we say
- 90% of what we say as we do
- Have we really satisfied the training and ongoing education priority for health care?

- Silos of education prevail...
Changing Demographics

- Today, one in four Americans is a member of a racial or ethnic minority group; by 2070, it will be one in two Americans.

- A much higher percentage of Americans under the age of 50 are members of minority groups than those over 50 – there may be important cultural differences between older patients and the people who provide services to them.

- In the future, the population over 65—the heaviest users of health care—will be far more diverse, and the majority of them will be women. Of the “oldest old” (those over 85) — 70% will be women.
Changing Demographics

- More than one in ten Americans was born in another country & are more likely to come from non-English-speaking cultures.

- Literacy is not a given; 10 million Americans cannot read in any language, and 40 million cannot read English at a 5th-grade level.

- AMA estimates that 90 million Americans do not understand what they are told by their providers.
Barriers to Patient Safety

29 Overall; Top 7 are:

- Competing priorities for scarce resources
- Lack of resources
- Availability & cost of PS technology
- Resistance to change
- Culture of blame
- Lack of senior leadership understanding & involvement with PS
- Negative culture that permits cover ups

Atkins & Cole, JAMA 5-05 (Delphi: Texas A&M)
5 Years After The IOM Report: “To Err Is Human”

- Regulation: A-
- Workforce Training Issues: B
- Information Technology: B-
- Error Reporting Systems: C
- Malpractice System: D+

Wachter, RM; Health Affairs; 11/2004
Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

Mission:

- To continuously improve the safety and quality of care provided to the public through the provision of health care accreditation and related services that support performance improvement in health care organizations.
Joint Commission Resources (JCR), Inc.

- A global, knowledge-based organization which disseminates information regarding accreditation, standards development and compliance, good practices, and health care quality improvement.

- Dedicated to helping health care organizations world-wide to improve the quality of patient care and achieve peak performance.
Joint Commission International

Mission:

- To improve the safety and quality of care in the international community through the provision of education, publications, consultation, evaluation, and accreditation services
“To continuously improve the safety and quality of care”

The Joint Commission on Accreditation of Healthcare Organizations
~ Overlapping Strategies ~

- Committed to continually enhance the value of its accreditation and certification programs.
  - The Joint Commission will strive to ensure that they are patient-centered, data-driven, relevant, and integral to the performance improvement activities of health care organizations.
### Accredited Programs

<table>
<thead>
<tr>
<th>Service</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory Care</td>
<td>1,234</td>
</tr>
<tr>
<td>Assisted Living</td>
<td>72</td>
</tr>
<tr>
<td>Behavioral Health Care</td>
<td>1,821</td>
</tr>
<tr>
<td>Critical Access Hospitals</td>
<td>268</td>
</tr>
<tr>
<td>Home Care</td>
<td>3,422</td>
</tr>
<tr>
<td>Hospitals</td>
<td>4,342</td>
</tr>
<tr>
<td>Laboratory</td>
<td>1,947</td>
</tr>
<tr>
<td>Long Term Care</td>
<td>1,364</td>
</tr>
<tr>
<td>Networks</td>
<td>21</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>14,712</strong></td>
</tr>
</tbody>
</table>

### Certified Programs

<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disease-Specific Care</td>
<td>229</td>
</tr>
<tr>
<td>Health Care Staffing</td>
<td>70</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>299</strong></td>
</tr>
</tbody>
</table>

As of December 30, 2005.
### Joint Commission International Branch Offices

#### France
- 13, Chemin du Levant
- Immeuble JB Say
- F-01210 Ferney-Voltaire
- France

#### Italy
- Via Beatrice d'Este, 20 20100
- Milano
- C.F.e.P.I. 04390030965
- Italy

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### No. of Accredited Organizations by Country

<table>
<thead>
<tr>
<th>Country</th>
<th>No. of Organizations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Austria</td>
<td>4</td>
</tr>
<tr>
<td>Brazil</td>
<td>6</td>
</tr>
<tr>
<td>China</td>
<td>2</td>
</tr>
<tr>
<td>Czech Republic</td>
<td>2</td>
</tr>
<tr>
<td>Denmark</td>
<td>7</td>
</tr>
<tr>
<td>Egypt</td>
<td>1</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>1</td>
</tr>
<tr>
<td>Germany</td>
<td>6</td>
</tr>
<tr>
<td>India</td>
<td>2</td>
</tr>
<tr>
<td>Ireland</td>
<td>8</td>
</tr>
<tr>
<td>Italy</td>
<td>4</td>
</tr>
<tr>
<td>Kingdom of Saudi Arabia</td>
<td>5</td>
</tr>
<tr>
<td>Philippines</td>
<td>1</td>
</tr>
<tr>
<td>Singapore</td>
<td>8</td>
</tr>
<tr>
<td>Spain</td>
<td>13</td>
</tr>
<tr>
<td>Thailand</td>
<td>1</td>
</tr>
<tr>
<td>Turkey</td>
<td>7</td>
</tr>
<tr>
<td>United Arab Emirates</td>
<td>1</td>
</tr>
</tbody>
</table>
Safety and Regulatory Issues

Evolution of Accreditation Process:

- Based in standards
  - Minimum to optimum achievable
- Transitioning from structure to outcomes-related functions
- CQI commitment
  - Focusing on what matters
Safety and Regulatory Issues

Persistent Accreditation Issues:
- Precision of standards
- Consistency of surveyors
- Perceptions of relevance
- Intermittent nature of process

Shared Visions, New Pathways
Committed to developing, utilizing, and maintaining valid and reliable performance measures.

- These measures are needed to support a credible, data-driven accreditation process and the publication of meaningful comparative performance information for the public.
Requirements that define performance expectations with respect to structure, process, and outcomes that must be substantially in place in an organization to enhance the safety and quality for patient care

- Performance Measurement Data
- Adverse Event Reporting
Core Measures
(Definition)

- Standardized sets of performance measures (usually disease- or condition-specific)
- Precisely defined specifications
- Can be uniformly embedded/adopted in extant systems
- Standardized data collection protocols
- Meet established evaluation criteria
Core Measure Set
(Definition)

- A unique grouping of performance measures carefully selected to provide, when viewed together, a robust picture of the care provided.
Core Measure Identification Process

Identify hospital priority measurement focus areas

- Acute myocardial infarction (implemented 2002)
- Heart failure (implemented 2002)
- Community acquired pneumonia (implemented 2002)
- Pregnancy and related conditions (implemented 2002)
- Surgical infection prevention (Implemented July 2004)
- Intensive care (Scheduled July 2005)
- Pain management (In development)
- Children’s asthma (In development)
- Hospital Based Inpatient Psychiatric Services (In development)
- DVT (In development)
Committed to addressing pressing public policy issues that impact the quality and safety of health care.

- The Joint Commission will convene thought leaders and subject-matter experts and will issue public policy recommendations.
<table>
<thead>
<tr>
<th>Topics</th>
<th># of Downloads</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Shortage– white paper</td>
<td>967,308</td>
</tr>
<tr>
<td>Emergency Preparedness – white paper</td>
<td>113,359</td>
</tr>
<tr>
<td>Organ Donation – white paper</td>
<td>92,647</td>
</tr>
<tr>
<td>Medical Liability – white paper</td>
<td>292,033</td>
</tr>
<tr>
<td>Improving the Quality of Pain Management Through Measurement and Action</td>
<td>638,938</td>
</tr>
<tr>
<td>Universal Protocol</td>
<td>157,880</td>
</tr>
<tr>
<td>Universal Protocol Implementation Guidelines</td>
<td>127,798</td>
</tr>
<tr>
<td>“Do Not Use” List</td>
<td>104,860</td>
</tr>
<tr>
<td>Standing Together Emergency Planning Guide</td>
<td>587,554</td>
</tr>
<tr>
<td>Speak Up Brochure</td>
<td>154,535</td>
</tr>
<tr>
<td>Universal Protocol Brochure (Wrong Site Surgery)</td>
<td>95,798</td>
</tr>
<tr>
<td>Organ Donation Brochure</td>
<td>46,937</td>
</tr>
<tr>
<td>Infection Control Brochure</td>
<td>150,934</td>
</tr>
<tr>
<td>Medication Management Brochure</td>
<td>50,446</td>
</tr>
</tbody>
</table>
Committed to ensure that the accreditation process is publicly accountable.

- The Joint Commission will provide meaningful and useful information about the performance of accredited organizations to the public.
Who is the Joint Commission?
The nation's leading standards-setting and accrediting body in health care; focused on improving the quality and safety of care provided by health care organizations.

What is Accreditation?
A distinction given to an organization when its performance meets or exceeds the Joint Commission's standards and quality expectations.

Why use Quality Check?
Quality Check is one source of accreditation and comparison information that a person can use to determine whether a health care organization will meet his or her needs.
SIP Measure Reporting

Symbol Key
- This Organization Achieved the Best Possible Results
- This Organization’s Performance is Above the Performance of Most Accredited Organizations
- This Organization’s Performance is Similar to the Performance of Most Accredited Organizations
- This Organization’s Performance is Below the Performance of Most Accredited Organizations
- Not Displayed

Accreditation Decision
Accredited.

Decision Effective Date
January 15, 2004

Accredited Programs
- Hospital
- Laboratory
- Home Care

Footnote Key
1. The Measure or Measure Set is not Reported.
2. The Measure Set Does Not Have an Overall Result.
3. The Number of Patients is Not Enough for Comparison Purposes.
4. The Measure Results are not Displayed.
5. The Organization Scored Above 90% but was Below Most Other Organizations.
6. The Measure Results are Not Statistically Valid.
7. The Measure Results are Based on a Sample of Patients.
8. The Number of Months with Measure Data is Below the Reporting Requirement.

For further information and explanation of the Quality Report contents, refer to the “Quality Report User Guide.”

<table>
<thead>
<tr>
<th>Achieving National Patient Safety Goals:</th>
<th>Compared to other JCAHO Accredited Organizations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Nationwide</td>
</tr>
<tr>
<td>Achieving National Quality Improvement Goals:</td>
<td></td>
</tr>
<tr>
<td>Heart Attack Care</td>
<td>+</td>
</tr>
<tr>
<td>Heart Failure Treatment</td>
<td>+</td>
</tr>
<tr>
<td>Pneumonia Care</td>
<td>+</td>
</tr>
<tr>
<td>Surgical Infection Prevention</td>
<td>+</td>
</tr>
<tr>
<td>- Blood Vessel Surgery</td>
<td>+</td>
</tr>
<tr>
<td>- Colon/Large Intestine Surgery</td>
<td>+</td>
</tr>
<tr>
<td>- Coronary Artery Bypass Graft</td>
<td>+</td>
</tr>
<tr>
<td>- Hip Replacement Surgery</td>
<td>+</td>
</tr>
<tr>
<td>- Open Heart Surgery</td>
<td>+</td>
</tr>
</tbody>
</table>
System ABC’s PFP Point Total Average = (3282.50/11) = 299
System ABC compared to other groups of hospitals from PFP Studies:

**PFP Means Across Various Groups of Hospitals - 2004 Studies**

<table>
<thead>
<tr>
<th>Group Name</th>
<th>PFP Point Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>System ABC</td>
<td>299</td>
</tr>
<tr>
<td>Solucient Benchmark Group</td>
<td>163</td>
</tr>
<tr>
<td>US News Benchmark Group</td>
<td>190</td>
</tr>
<tr>
<td>Random Control Group</td>
<td>206</td>
</tr>
<tr>
<td>For Cause Group</td>
<td>243</td>
</tr>
<tr>
<td>Conditional Accreditation Status</td>
<td>348</td>
</tr>
<tr>
<td>Preliminary Denial of Accreditation Status</td>
<td>348</td>
</tr>
</tbody>
</table>
Top 4 Priority Focus Area (PFAs) for NYCHHC
1. Communication
2. Quality Improvement Expertise/Activities
3. Staffing
4. Information Management

Top 4 Priority Focus Area (PFAs) for all JCAHO-accredited hospitals
1. Communication
2. Information Management
3. Staffing
4. Patient Safety

Top 4 Clinical/Service Groups’ (CSGs) for NYCHHC System
1. General Surgery
2. Cardiology
3. Pulmonary
4. Psychiatry

Top 4 NYCHHC Hospitals by PFP Point Total
1. Hospital F (476.00)
2. Hospital K (442.00)
3. Hospital L (348.50)
4. Hospital D (298)

Mean (Average) PFP Point Total
- 299

Median (Middle) PFP Point Total
- 265

Range of Point Totals
- 220.50 – 476
Speak-Up Campaign

Speak Up

Speak Up Initiatives
There are no copyright or reprinting permissions required for the Speak-Up materials or copy. In references to the materials or copy, we do ask that the Joint Commission on Accreditation of Healthcare Organizations be credited as the source for the materials or copy. For more information see "About the Speak-Up Program.

To order Speak-Up materials call 1-877-223-6566.

Speak Up | Infection Control | Living Organ Donation | Medication Mistakes | Planning Your Recovery | Research Studies | Wrong Site Surgery

Speak Up: Help Prevent Errors in Your Care Brochure
* Speak Up: Help Prevent Errors in Your Care Brochure
  (Requires Acrobat Reader)
* View all Speak-Up brochures by health care setting

Speak Up: Help Prevent Errors in Your Care Video
* Video Presentation on Speak Up
  (Requires Windows Media Player)

Infection Control Brochure
* Three Things You Can Do To Prevent Infection
  (Requires Acrobat Reader)
* Three Things You Can Do To Prevent Infection (Spanish)
  (Requires Acrobat Reader)
* Download the brochure artwork print file
  (Requires Quark 6.0+)

Infection Control Poster
* Three Things You Can Do To Prevent Infections
  (Requires Acrobat Reader)
* Download the poster artwork print file
  (Requires Quark 6.0+)

Infection Control Video
* Preventing Infections As The Weather Turns Colder - For Adults
  (Requires Windows Media Player)
Committed to making patient safety an imperative in all accredited organizations.

- This will be accomplished through the standards and policies of the Joint Commission and through collaboration with other patient safety leadership organizations.
Joint Commission: Sentinel Event Policy

Established in January 1996 with the following goals:

- To have a positive impact in improving care
- To focus attention on underlying causes and risk reduction
- To increase the general knowledge about sentinel events, their causes and prevention
- To maintain public confidence in the accreditation process
Sentinel Events Subject to Review Under the Policy

(Applies only to recipients of care)

Event resulting in unanticipated patient death or major permanent loss of function (unrelated to the natural course of the patient's illness or underlying condition)

- OR -
The event involves one of the following:

- Suicide in a round-the-clock staffed care setting or within 72 hours of discharge
- Abduction of a patient (any age)
- Infant discharge to wrong family
- Rape
- Hemolytic transfusion reaction
- Surgery on wrong patient or wrong body part
Sentinel Events Subject to Review Under the Policy

(Appplies only to recipients of care)

Or, the event involves one of the following:

- Unintended retention of a foreign object after surgery
- Severe neonatal hyperbilirubinemia
  - (>30 milligrams/deciliter)
- Radiation overdose
  - Fluoroscopy > 1500 rad to a single field
  - Radiotherapy to the wrong body region or >25% above the planned dose
### Root Causes of Sentinel Events (All categories; 1995-2004)

<table>
<thead>
<tr>
<th>Cause</th>
<th>Percent of 3231 events</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication</td>
<td>50</td>
</tr>
<tr>
<td>Orientation/training</td>
<td>40</td>
</tr>
<tr>
<td>Patient assessment</td>
<td>30</td>
</tr>
<tr>
<td>Staffing</td>
<td>20</td>
</tr>
<tr>
<td>Availability of info</td>
<td>15</td>
</tr>
<tr>
<td>Competency/credentialing</td>
<td>10</td>
</tr>
<tr>
<td>Procedural compliance</td>
<td>10</td>
</tr>
<tr>
<td>Environ. safety / security</td>
<td>5</td>
</tr>
<tr>
<td>Leadership</td>
<td>5</td>
</tr>
<tr>
<td>Continuum of care</td>
<td>5</td>
</tr>
<tr>
<td>Care planning</td>
<td>5</td>
</tr>
<tr>
<td>Organization culture</td>
<td>5</td>
</tr>
</tbody>
</table>

### Root Causes of Sentinel Events (All categories; 2005)

<table>
<thead>
<tr>
<th>Cause</th>
<th>Percent of 3231 events</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication</td>
<td>70</td>
</tr>
<tr>
<td>Orientation/training</td>
<td>40</td>
</tr>
<tr>
<td>Patient assessment</td>
<td>30</td>
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<tr>
<td>Environ. safety / security</td>
<td>5</td>
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<td>Leadership</td>
<td>5</td>
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<tr>
<td>Continuum of care</td>
<td>5</td>
</tr>
<tr>
<td>Care planning</td>
<td>5</td>
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<tr>
<td>Organization culture</td>
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</tbody>
</table>

### Sentinel Event Trends:

Total Sentinel Events Reported by Year

- 1995: 10
- 1996: 15
- 1997: 50
- 1998: 100
- 1999: 150
- 2000: 200
- 2001: 300
- 2002: 400
- 2003: 500
- 2004: 600
- 2005: 800
<table>
<thead>
<tr>
<th></th>
<th>Sentinel Event Alerts</th>
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<tbody>
<tr>
<td>1</td>
<td>Potassium chloride</td>
</tr>
<tr>
<td>2</td>
<td>Policy issues</td>
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<tr>
<td>3</td>
<td>Policy issues</td>
</tr>
<tr>
<td>4</td>
<td>Policy issues</td>
</tr>
<tr>
<td>5</td>
<td>Policy issues</td>
</tr>
<tr>
<td>6</td>
<td>Wrong site surgery</td>
</tr>
<tr>
<td>7</td>
<td>Suicide</td>
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<tr>
<td>8</td>
<td>Restraint deaths</td>
</tr>
<tr>
<td>9</td>
<td>Infant abductions</td>
</tr>
<tr>
<td>10</td>
<td>Transfusion errors</td>
</tr>
<tr>
<td>11</td>
<td>High Alert Medications</td>
</tr>
<tr>
<td>12</td>
<td>Op/post-op complications</td>
</tr>
<tr>
<td>13</td>
<td>Impact of SE Alert</td>
</tr>
<tr>
<td>14</td>
<td>Fatal falls</td>
</tr>
<tr>
<td>15</td>
<td>Infusion pumps</td>
</tr>
<tr>
<td>16</td>
<td>Proactive risk reduction</td>
</tr>
<tr>
<td>17</td>
<td>Home fires (O2 therapy)</td>
</tr>
<tr>
<td>18</td>
<td>Kernicterus</td>
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<tr>
<td>19</td>
<td>Look-alike, sound-alike drugs</td>
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<tr>
<td>20</td>
<td>Kreutzfeldt-Jakob disease</td>
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<td>21</td>
<td>Medical gas mix-ups</td>
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<td>22</td>
<td>Needles &amp; sharps injuries</td>
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<td>23</td>
<td>Dangerous abbreviations</td>
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<td>24</td>
<td>Wrong-site surgery #2</td>
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<td>25</td>
<td>Ventilator-related events</td>
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<td>26</td>
<td>Delays in treatment</td>
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<td>27</td>
<td>Bed rail deaths &amp; injuries</td>
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<tr>
<td>28</td>
<td>Nosocomial infections</td>
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<td>29</td>
<td>Surgical fires</td>
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<td>30</td>
<td>Perinatal deaths</td>
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<td>31</td>
<td>Anesthesia awareness</td>
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<td>32</td>
<td>Kernicterus #2</td>
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<td>33</td>
<td>PCA by proxy</td>
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<tr>
<td>34</td>
<td>Intrathecal vincristine</td>
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<tr>
<td>35</td>
<td>Wrong route / wrong tube</td>
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<tr>
<td>36</td>
<td>Medication reconciliation</td>
</tr>
<tr>
<td>37</td>
<td>Device Connections</td>
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</tbody>
</table>
National Patient Safety Goals

- Selection of the Goals and requirements is guided by a panel of experts:
  
  **Sentinel Event Advisory Group**

- Each year, a set of Goals & their Requirements are identified from a variety of sources

- The Goals and their Requirements are field reviewed & published by mid-year for the coming calendar year
2005 National Patient Safety Goals

1. Patient identification
2. Communication among caregivers
3. Medication safety
4. Wrong-site surgery
5. Infusion pumps
6. Clinical alarm systems
7. Health care-associated infections
8. Reconciliation of medications
9. Patient falls
10. Flu & pneumonia immunization
11. Surgical fires
12. NPSG implementation by network components
New Goals & Requirements for 2006

- Add to Goal 2: “Hand-off” Communication (All programs)
- Add to Goal 3: Label meds on sterile field (Hospitals, Ambulatory and Office-based Surgery)
- New Goal 13: Patient involvement in safety (Home Care, Lab, Assisted Living, DSC)
- New Goal 14: Pressure ulcer prevention (Long Term Care)
2006 National Patient Safety Goals

1. Patient identification
2. Communication among caregivers
3. Medication safety
4. Wrong-site surgery Universal Protocol
5. Infusion pumps
6. Clinical alarm systems
7. Health care-associated infections
8. Reconciliation of medications
9. Patient falls
10. Flu & pneumonia immunization
11. Surgical fires
12. NPSG implementation by network components
13. Patient involvement
14. Pressure ulcers
2006 National Patient Safety Goals

Goal #4: Eliminate wrong-site, wrong-patient, wrong-procedure surgery. [Surveyed under the Universal Protocol]

Requirement #4.a.

Use a pre-op verification process, such as a checklist, to confirm appropriate documents are available.

Requirement #4.b.

Implement a process to mark the surgical site and involve the patient in the process.
SCALPEL, PLEASE
Inpatient surgeries, 1994-2004

<table>
<thead>
<tr>
<th>Year</th>
<th>Surgeries (in thousands)</th>
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<tbody>
<tr>
<td>1994</td>
<td>9,834</td>
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<tr>
<td>1995</td>
<td>9,701</td>
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<td>1996</td>
<td>9,546</td>
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<td>9,509</td>
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<td>9,736</td>
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<td>9,540</td>
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<td>2000</td>
<td>9,729</td>
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<td>2002</td>
<td>10,105</td>
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<tr>
<td>2003</td>
<td>9,941</td>
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<tr>
<td>2004</td>
<td>10,050</td>
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</table>

Root Causes of Wrong Site Surgery

Root Causes of Wrong Site Surgery
(2005)
Provisions of the Universal Protocol

- Preoperative verification process
  - Relevant pre-op tasks completed and information is available and correct

- Surgical site marking
  - Unambiguous mark, visible after prep & drape
  - Right/left, multiple structures or levels

- “Time out” immediately before starting
  - Involves entire team; active communication
  - Fail-safe model: “No go” unless all agree

- Applicable to invasive procedures in all settings
Wrong-site Surgeries

Sentinel Event Trends:
Wrong-site Surgeries Reported by Year

- S. E. Alert #24 December 2001
- NPSGs January 2003
- W.S.S. Summit May 2003
- U.P.
- S. E. Alert #6 August 1998

Public Disclosure of Compliance with National Patient Safety Goals

- **Aggregate data**
  - Data from 2003 - 2005 surveys posted on Joint Commission web site

- **Individual health care organizations:**
  - Compliance with specific requirements
  - Revised "Quality Reports" — on web site since mid-year 2004
Joint Commission
International
Center for Patient Safety

Partnering for Solutions in Systems Improvement
Co-sponsored by Joint Commission & JCR
Initiated in March 2005
Matrix organization structure
Domestic & International priorities
Regional Advisory Groups
Expert Panels
Website primary communication tool
Discussion Forums available – secure
MISSION

To continuously improve patient safety in all health care settings.

VISION

To become the trusted resource for improving health care worldwide by providing pre-eminent solutions and expertise in patient safety.

Engagement of key audiences that include patients and families, health care practitioners, and all types of health care organizations in complementary efforts towards improving patient safety!
Collaboration & Solutions:

- Designation of Joint Commission and JCI as the **WHO Collaborating Centre for Patient Safety Solutions**
- A Component of the World Alliance for Patient Safety initiative
- Operational implementation is via the Joint Commission International Center for Patient Safety
Collaboration & Partnering
Patient Safety “Solutions”
Information Distribution
Educational Programs
Patient Safety Research
Public Policy-Advocacy

Patient Safety Legislation & PSO
Processes of Solutions
Development, Assessment
and Dissemination
– Complex!!
Definition:

- A Safety Solution is any system design or intervention that has demonstrated the ability to prevent or mitigate patient harm stemming from the processes of health care.
Challenges of Solution Identification:

- Selecting solutions with broad application
- Adapting solutions for all countries
  - Developing
  - Transitional
  - Developed

- Dissemination vs Implementation
In focus...

- Tip of the Week: Hand Hygiene  More
- Case Study: Hospital and Ambulatory Care Organizations Work to Prevent Wrong Site Surgery  More
- Case Study: Enhancing Patient Safety Through Research  More
- Guest Commentary: Beyond the Moral Imperative: The Business Case for Patient Safety  More
- Ensuring the Safety of Your Special Patient Populations  More

Networking Communities

- Polling Question: Infection prevention and control strategies
- Patient Safety Forums

Complimentary Patient Safety Resources

Tools, case studies, good practice examples, awards, links to patient safety resources...  More

Patient Safety Products & Services

Patient safety products and services (audio conferences, publications, education programs, learning courses)...  More
What Is On The Radar Screen?
Top 5 Issues for CEOs

1. Safety & Quality
2. Revenue Enhancement
3. Capitol Enhancement
4. Technology Investment
5. Medical Staff Development

2005 - Cejka & Solucient
Do one brave thing today... then run like hell!
Physician Engagement

**Guild Mentality:**

- Establish criteria for admittance and licensure
- Hold members accountable to a level of performance higher than legal requirements
- Ethic that holds service to others above economic self-interests
- Define the organizational & service components of the profession
Physician Engagement

- Traditionalist:
  - Prestige vs Shame (Pride)

- Boomer:
  - Acquisition vs Guilt (Status)

- Gen Xer:
  - Belonging vs Rejection (Security)
Physician Engagement

- Professionalism is in jeopardy

- When what you do is disconnected from what you value, you begin to feel anger, fear, helplessness & without energy...

- Patients are just a transaction !?!
Safety – Easy to Hard Phase

- Safety Science Exists
- Safety Tools Exist
- Success Examples Exist

2006 - McCarthy & Blumenthal

Cultures:
- Customary Beliefs, Values & Behaviors (incl. Tradition)
- Shared by Members of a Group

Change of One – Impacts Others
A Medical Culture Paradox

First, Do No Harm

&

To Err is Human
We need YOU - to lead & work together for the long term!

Thank You for the Attention!