LEADING the way to ZERO™
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The Joint Commission
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One Shared Vision
All people always experience the safest, highest quality, best-value health care across all settings

The Joint Commission Enterprise
Largest accrediting body in health care & crosses continuum of care
Performance improvement experts; quality and safety resource
Creates solutions for high reliability health care

Exclusive Cross-continuum Capabilities
Accreditation & Certification
Software Education Publications
High Reliability Training Tools & Resources

Enterprise Comprehensive Offerings
Designed to Support a System’s Quality / Safety Journey
Supplemented by a wide range of complimentary tools & services unique to The Joint Commission
Supporting Services Education, software & publications from JCR
High Reliability Services Includes online tools, programs & training from the Center for Transforming Healthcare

AT THE FOREFRONT
LARGEST Hospital Accradiator
Accreditation & Certification
500 Programs
21,000+ Organizations
13,000+ Surveys/Year
100+ Countries
1,000+ Pursuing High Reliability
Zero Patient Harm is Achievable

“The idea means to me that we will absolutely cause no harm to any patient at any time. Zero harm means identifying every patient, every specimen, collecting it appropriately from the very beginning, and then maintaining that specimen’s integrity and the quality throughout testing process. It’s what we do every day.”

“Zero harm means all of our results, whoever turns them out, would be accurate, so it would be something where we’re not turning out a falsely increased glucose, for example, where we’d have to make the patient have to come in and have a bunch of other tests done to check on it, when really it was just a bad result. So, they want everyone to be able to turn out very accurate results so that the patient can be treated correctly the first time, and not need follow up care, or something like that. It’s already what we’re striving for.”

We Advance Patient Quality & Safety Beyond Accreditation
High Reliability Model for Health Care

Leadership
Safety Culture
Robust Process Improvement

Commitment to zero harm
Empowering staff to speak up
Systematic, data-driven approach to complex problem solving


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)

70% Medical decisions based off of laboratory tests
35,000 Laboratories in the US performing laboratory testing
7 to 10 Billion Lab tests performed in the US each year

“We're not librarians where a book gets put in a wrong row, every sample is a life.” – Medical Technologist
“While not all testing mistakes will injure or kill, the precise nature of the work means labs must follow regulations and treat every potential risk as an ‘avoidable risk’.”

—Paul Epner, past president of the Clinical Laboratories Management Association.

What could go wrong in the laboratory?
- Expired products are used and could lead to erroneous results.
- Blood that is supposed to be kept cold before a transfusion isn’t.
- Samples are incorrectly labeled or swapped between patients.

The FDA concluded that lab test errors are harming patients, and they listed many serious health consequences:
- Unnecessary medical treatment
- Diagnosis of actual condition is delayed
- Expensive treatments
- Surgery to remove healthy organs (ovaries, for example)
- Appropriate treatment is delayed
- Healthy pregnancy is aborted, or a child is born with birth defects
- Cancer treatment is inappropriate, harmful, or ineffective

What 99.9% in a Community Hospital looks like:

**Blood Bank**
- 10,906 units Blood Components Transfused
- 11 Transfusion Reactions

**Pharmacy**
- 3,416,600 medication doses dispensed
- 3,417 would be Improperly Dispensed

**Pathology**
- 43,900 Specimens processed
- 44 Wrong Diagnoses

**Obstetrics**
- 4,300 Babies Delivered
- 4 babies going home with the wrong parents!

In order for the laboratory to have a positive impact on diagnostic errors, it is necessary to become part of the interdisciplinary patient-centered care team. Laboratory professionals need to view their services as contributing to patient outcomes, not just generating results.

Plebani M. Diagnostic errors and laboratory medicine – causes and strategies. EJIFCC. 2015 Jan; 26(1): 7-14

Zero Harm IS Achievable
How Safe is Healthcare?

- Dangerous (>1/1,000)
- Ultra Safe (<1/1M)

Number of Encounters for Each Fatality

Total Lives Lost per Year

- Mountaineering
- Bungee Jumping
- Driving in US
- Chartered Flights
- Chemical Manufacturing
- Scheduled Commercial Airlines
- European Railroads
- Nuclear Power

Transform health care into a high-reliability industry


Current State: Quality

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

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

Current State of 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

Joint Commission Center for Transforming Healthcare

To transform health care into a high-reliability industry by developing highly effective, durable solutions to health care’s most critical safety and quality problems in collaboration with health care organizations, by disseminating the solutions widely, and by facilitating their adoption

High Reliability Model for Health Care

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Evolution of Healthcare

Swiss Cheese model of Error


TRUST

IMPROVE

REPORT

Unsafe conditions or daily annoyances?


Evolution of Safety Culture

- Today, we mostly react to adverse events
- Unsafe conditions are further upstream from harm than close calls
- Close calls 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
What is RPI®?

- Robust Process Improvement® or RPI® is a set of tools, methods, and training programs adopted by many organizations, including The Joint Commission, to improve business processes and results. Some health care organizations use RPI® to improve clinical quality and safety outcomes.
- RPI® is a blended model incorporating Lean, Six Sigma and formal Change Management methods concurrently, utilizing different parts of the tool kit to address specific improvement problems.
- RPI® is a pathway to high reliability.

The most detrimental error is failure to learn from an error.
~James Reason

LEADING the way to ZERO™
Through Joint Commission Laboratory Accreditation

- SAFER™ matrix
- Tracer methodology
- Employed professional surveyors
- Increased awareness and engagement with hospital leadership
- Allows organizations to speak the same language across all patient care settings

SAFER™ Matrix

- A transformative approach for identifying and communicating risk levels associated with deficiencies cited during surveys
- Provides one comprehensive visual representation of survey findings
- Helps organizations prioritize and focus corrective actions

Survey Analysis for Evaluation Risk
SAFER™ Matrix

Unique Tracer Methodology

- “Trace” the care experiences that a patient had while at an organization
- Analyzes the organization’s system of providing treatment or services using actual patients as the framework for assessing standards compliance
- Highlights the critical connection between the lab, hospital and the patient
Laboratory’s Impact on Patient Care

− “Laboratory medicine influences 60% to 70% of all critical decisions that affect downstream patient care.”
  Clin Chem, 1996;42:813-816

− Survey readiness ensures test results are accurate

− Survey readiness is part of your journey of “Leading the Way to Zero”

Survey Ready = Patient Ready
Under Laboratory Director Leadership:
− Prepare every day
− Review the standards
− Engage your staff
− Assess your risks proactively
− Promote a Culture of Safety and a Just Culture
− Promote a questioning attitude
− Use the Tracer Methodology: connect the lab with other departments
− Create a safe journey for patients

Zero Harm: An Achievable Goal

LEADING the way to ZERO*

If not us, then who?
If not now, then when?

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