High Reliability Introductory Webinar

Joint Commission Center for Transforming Healthcare
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Chief Medical Officer and Vice President

Illinois Hospital Association
May 3, 2016
Operating-Room Fire at Hospital Burns Patient, Prompts Changes

FirstHealth of the Carolinas officials should know by the end of the month whether they have taken adequate corrective steps to prevent operating room fires like the one recently that burned the neck and shoulders of a patient during an emergency surgery at Moore Regional Hospital.

The N.C. Division of Health Service Regulation placed Moore Regional on “immediate jeopardy” status following an
Average Rate Per Exposure of Catastrophes and Associated Deaths Per Activity

Current State of 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
- Improvement difficult to sustain/spread
- Getting to zero, staying there is very rare
Performance

We have learned from:

- HROs (academics, nuclear power, aviation)
- Major corporations
- Joint Commission Center for Transforming Healthcare: Extensive experience with 27 hospitals and systems that use RPI
- Joint Commission: intimate knowledge of health care systems and internal experience
High Reliability in Health Care

- Many patients still suffer preventable harm and experience health care across the continuum that is far from excellent
- A goal of zero preventable harm
- Safety is the highest priority
- The focus on safety leads to improvement across the care continuum
ZERO
HAI Hospital Scorecard

### Sugar Land Hospital HAI Scorecard

<table>
<thead>
<tr>
<th></th>
<th>ICU CLABSI</th>
<th>Floor CLABSI</th>
<th>ICU CAUTI</th>
<th>Floor CAUTI</th>
<th>Total SSI</th>
<th>Perf Std SSI</th>
<th>NHSN SSI</th>
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</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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</table>

<table>
<thead>
<tr>
<th></th>
<th>Hip</th>
<th>Knee</th>
<th>ORIF</th>
<th>MRSA</th>
<th>Clostridium difficile</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
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</table>

**Number of HAIs in one month**

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High Reliability in Health Care

QUALITY

SAFETY

First, Do No Harm

PATIENT-CENTERED

TIMELY

EFFICIENT

EFFECTIVE

EQUITABLE
HIGH RELIABILITY

- Improves organizational effectiveness
- Improves organizational efficiency
- Improves customer satisfaction
- Improves compliance
- Improves organizational culture
- Improves documentation
Excellence in patient care for every patient, every time
Patient Safety Systems Chapter for the Hospital program

The 2015 Comprehensive Accreditation Manual for Hospitals

includes the new “Patient Safety Systems” chapter, a blueprint for leaders that uses existing standards to achieve an integrated approach to patient safety. The Joint Commission believes so strongly in this approach that the chapter is being made available online to anyone who wishes to read it.
How Do We Get from Low to High Reliability?
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
HIGH RELIABILITY MODEL

Leadership
Commitment to zero patient harm

Safety Culture
Empowering staff to speak up

Robust Process Improvement®
Systematic, data-driven approach to complex problem solving

High Reliability Model

Leadership Commitment
- Board
- CEO/Management
- Physicians
- Quality Strategy
- Quality Measures
- Safe Adoption of IT

Adoption of Safety Culture
- Trust
- Accountability
- Identifying Unsafe Conditions
- Strengthening Systems
- Assessment

Robust Process Improvement®
- Methods
- Training
- Spread

Stages of Maturity: Beginning ➔ Developing ➔ Advancing ➔ Approaching
LEADERSHIP COMMITMENT AND ACTION

Leadership at all levels...
Evolution of Safety Culture

Today: React after adverse events

Close Calls

Unsafe conditions

Proactive assessment of safety systems
ROBUST PROCESS IMPROVEMENT®

Facilitating Change

Lean

Six Sigma

ACCEPTANCE & ACCOUNTABILITY

RESPECT FLOW

REDUCES VARIATION ACCURACY

FOCUS IS ON THE PATIENT
Facilitating Change

Plan
Inspire People
Launch
Support the Change

Facilitating Change
A Systematic Approach for Complex Problem Solving

Define the problem

Measure the impact & discover specific causes

Solutions are targeted to each specific cause

DEFINE
MEASURE & ANALYZE
IMPROVE & CONTROL
## Add Fall Event

Complete Fall Event form for ALL falls that occur on the project unit(s)

- Falls with and without injury
- Unintentional and intentional falls

Questions presented will vary based on how previous questions are answered

* indicates required field

### Fall Event Data Collection Form

<table>
<thead>
<tr>
<th>Patient ID (Last 4 – 5 digits of MR#)</th>
<th>Room Number</th>
<th>Date of Fall</th>
<th>Time (Format: 01:22 AM, type A for AM or P for PM)</th>
<th>Time of Last Rounding (Format: 01:23 AM; type A for AM or P for PM)</th>
<th>Staff : Patient Ratio</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

- Was the fall determined to be intentional? *
- Was the patient identified as a fall risk? *(If no fall risk assessment was performed on the patient, select NA)* *
- Was the patient discharged prior to fall? *
- Number of staff required to assist this patient
- Did the fall occur during shift change?
- Has the patient fallen previously during this hospital stay? *
- Did the fall result in injury to the patient? *

Download Data Collection Form
# Robust Process Improvement® Drives Results

<table>
<thead>
<tr>
<th>Center Projects</th>
<th>Results(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hand hygiene</td>
<td>71↑</td>
</tr>
<tr>
<td>Hand-off communication failures</td>
<td>56↓</td>
</tr>
<tr>
<td>Wrong site surgery risks</td>
<td></td>
</tr>
<tr>
<td>– Scheduling</td>
<td>46↓</td>
</tr>
<tr>
<td>– Pre-op</td>
<td>63↓</td>
</tr>
<tr>
<td>– Operating Room</td>
<td>51↓</td>
</tr>
<tr>
<td>Colorectal SSIs</td>
<td>32↓</td>
</tr>
<tr>
<td>Falls with injury</td>
<td>62↓</td>
</tr>
</tbody>
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Robust Process Improvement

More than tools...

- Strategic project selection
- Common language
- Competency-based deployment
- Project management
- Data driven analysis is critical for complex problems
Robust Process Improvement: Sustainability

Don’t confine training to group of experts
– Aim to spread improvement approach throughout system

Transformation occurs when:
– It becomes “the way we work” every day
– Front-line employees see opportunities and have the tools to initiate improvement
– Enables a learning culture
Performance Improvement

Sustaining and Spreading Improvement in Hand Hygiene Compliance
Collaboration with many health care organizations...
Illinois Hospital Association in collaboration with the Joint Commission Center for Transforming Healthcare

High Reliability Initiative
High Reliability Program

- CEO commitment and participation
- Senior management team participation: CFO, CMO, CNO, COO, Human Resources, Risk Management, Quality & Patient Safety leads
- 2016: High reliability self-assessment (Oro™ 2.0)
- Educational webinars
Organizational Assessment & Resource Library

- 49 questions with branching logic for hospital senior leadership
- Evaluates level of maturity in 14 components

Provides leading indicator information about strengths, opportunities, and potential investment strategies for achieving performance

Alignment is critical for the high reliability journey
What does it take?

Buy in from CEO

Determine senior leader participants

Self-Assessment

- Pre group meeting: participants take the assessment (20 minutes)
- Senior leadership group meeting, ideally with a facilitator: 2 hours
- Post group meetings: time commitment varies. Review of results, strategic action planning
CEO participation is essential

Clinical leaders (e.g. CMO, CNO, VP Medical Affairs)

Administrative leaders (COO, CFO)

Board chair/Board Quality Committee Chair

Quality and Patient Safety leaders (e.g. VP PI, Patient Safety Office, Risk Management)

Ideal participant group size is no more than 15 to allow in-depth conversation and leadership perspective
Assessment Results

Surveyors do not have access to organization specific data within Oro™ 2.0

Results Comparison (All Participants)

Mock Test-General Hospital
HCO ID: 337843

Completed Date: 3/27/2014

<table>
<thead>
<tr>
<th>Area</th>
<th>Leadership</th>
<th>Safety Culture</th>
<th>Performance Improvement</th>
</tr>
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<tbody>
<tr>
<td>Component</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>P1</td>
<td></td>
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<td>P2</td>
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<tr>
<td>P6</td>
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Maturity Stage

<table>
<thead>
<tr>
<th>Leadership</th>
<th>Beginning</th>
<th>Developing</th>
<th>Advancing</th>
<th>Approaching</th>
</tr>
</thead>
<tbody>
<tr>
<td>Board</td>
<td>Board quality focus is nearly exclusively on regulatory compliance</td>
<td>Full Board’s involvement in quality limited to hearing reports from its quality committee</td>
<td>Full board engaged in development of quality goals and approval of quality plan; regularly reviews adverse events and progress on quality goals</td>
<td>Board commits to goal of high reliability for all clinical services</td>
</tr>
<tr>
<td>CEO/management</td>
<td>CEO/management quality focus is nearly exclusively on regulatory compliance</td>
<td>CEO acknowledges need for plan to improve quality; delegates development and implementation of plan to subordinate</td>
<td>CEO leads development and implementation of proactive quality agenda</td>
<td>Management aims for zero failure rates for all vital clinical processes; some demonstrate zero or near-zero failure rates</td>
</tr>
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| Physicians | Quality is not identified as central strategic imperative | Quality is one of many competing strategic priorities | Quality is one of our organization’s top 3 or 4 strategic priorities | Quality is the highest priority strategic goal of the organization |

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Resource Library

Selected Component: Performance Improvement > Methods

Resources

Peer Review Journal Article

**Demonstrating High Reliability on Accountability Measures at The Johns Hopkins Hospital**

This article discusses how the The Johns Hopkins Hospital implemented a comprehensive conceptual model to significantly improve performance on the Joint Commission’s accountability measures and thereby achieve recognition by the Top Performer on Key Quality Measures program. The performance goal was achieved for 82% of the measures in 2011 and 95% of the measures in 2012. With support from leadership and a conceptual model to communicate goals, use robust improvement methods, and ensure accountability, The Johns Hopkins Hospital achieved high reliability for The Joint Commission accountability measures.


Last Posted Date: 8/6/2015

Peer Review Journal Article

**Memorial Hermann: High Reliability from Board to Bedside**

Memorial Hermann Health System’s High Reliability Journey from Board to Bedside initiative focuses on providing compassionate and operationally and financially efficient care by concentrating leadership and employee attention on high-reliability behaviors, evidence-based care, and harm prevention.

Shabot, M.; Monroe, D.; Inurria, J.; Garbade, D.; and France, AC.

Last Posted Date: 8/6/2015

Peer Review Journal Article

**Improving Hand Hygiene at Eight Hospitals in the United States by Targeting Specific Causes of Noncompliance**

The article discusses a quality improvement project aimed to achieve adherence to hand hygiene practices at eight hospitals using change management methods drawn from human factors engineering. Lean, Six Sigma, and change management tools were used to identify specific causes of hand hygiene noncompliance at individual hospitals. Each hospital customized its improvement efforts by focusing on the causes most prevalent at its own facility and yielded a significant improvement in handwashing compliance.

Chassin, M.; Mayer, C.; and Nether, K.

Last Posted Date: 8/6/2015
Oro™ 2.0

Quick Access via the Center’s Website
www.centerfortransforminghealthcare.org
High Reliability Collaborations

South Carolina Safe Care Commitment

South Carolina Hospital Association

Michigan Health & Hospital Association
Keystone Center
Launch

- High reliability is achievable
- Striving for high reliability is not a project
  - Leadership commitment to goal of zero
  - Fully functioning culture of safety
  - Highly effective improvement capacity

- Enhances an organization’s ability to produce better outcomes in many different areas in addition to safety
THANK YOU

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www.centerfortransforminghealthcare.org