




# **Achieving Consistent Excellence in Health Care Quality**

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University of Texas System  
Inaugural Clinical Safety and Effectiveness  
Conference  
Austin, TX  
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# State of Quality

- 
- ▶ Despite our best efforts, serious quality and safety problems persist:
    - Serious preventable complications
    - Underuse of effective care
    - Overuse
  - ▶ Many problems are highly visible
  - ▶ Stakeholders are demanding excellence in unprecedented ways

# A Model That Works

TJC hospitals have improved markedly on core measures in use since 2002; several are at high levels of consistent excellence

## Acute MI: 2007 Hospital Performance

	<u>US avg(%)</u>	<u>% &gt; 90%</u>
Aspirin on arrival	97	96
BB on discharge	97	94
ACE inhibitors	92	69

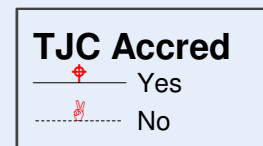
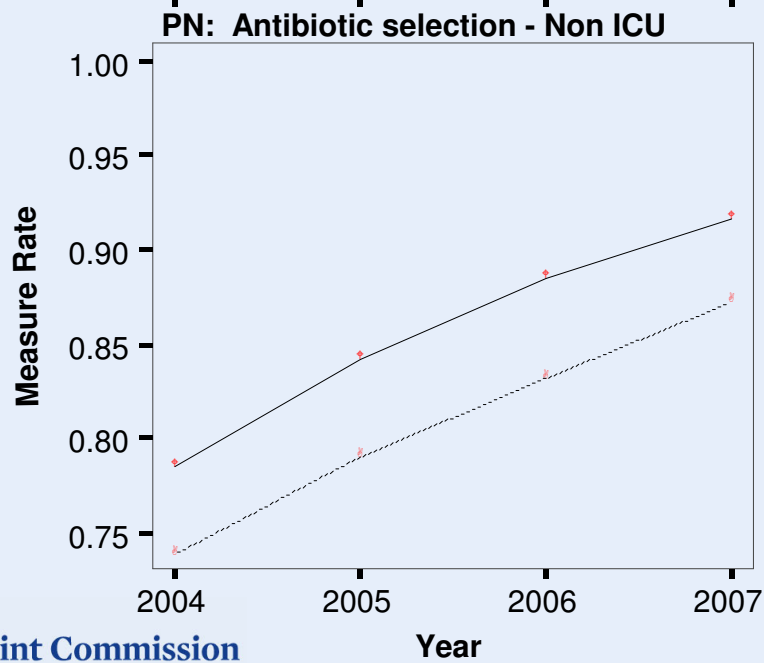
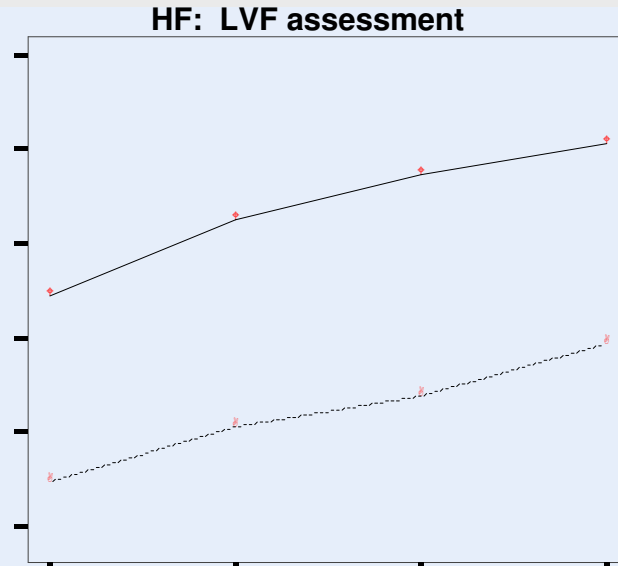
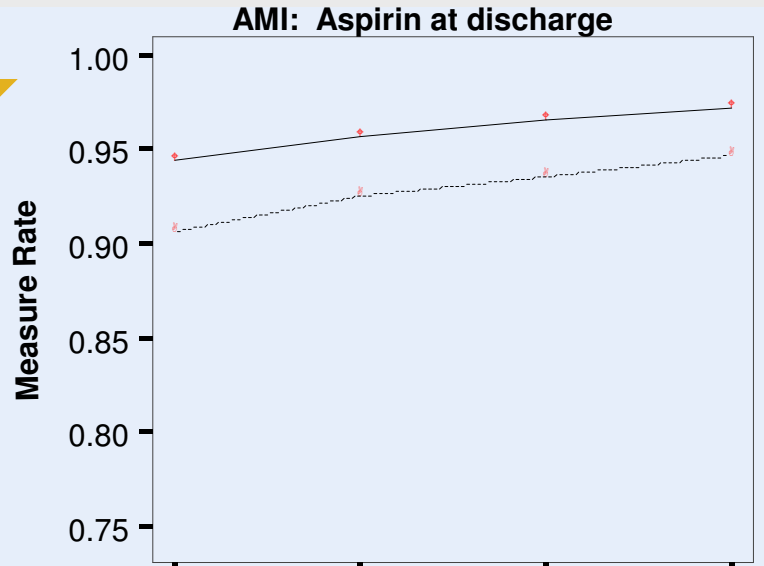
# A Model That Works

More recent measures need more work.  
Surgical measures: first full year was 2005

Antibiotic prophylaxis in surgery:  
2007 Hospital Performance

	<u>US avg(%)</u>	<u>% &gt; 90%</u>
First dose w/in 1h	89	54
Stopped w/in 24h	86	38

# TJC Accreditation Makes a Difference



# Improving Measurement

- ▶ TJC created national measurement of quality for hospitals; AHA, then CMS
- ▶ A great deal of real-world experience
  - Many measures work well; some don't
  - Must replace bad measures
- ▶ No formal process to assess that experience, learn from it, and act on it
- ▶ TJC working hard to achieve this goal

# The Changing Quality Landscape

- ▶ Health care must assimilate many new drugs, devices, procedures, equipment
- ▶ All organizations have scarce QI resources
- ▶ Joint Commission strongly influences how those resources are used
- ▶ Obligation to maximize the health benefit of our measures and standards
- ▶ Organizations want to know how to improve
- ▶ Public stakeholders are impatient

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## Monday: Wrong kidney removed from Methodist cancer patient

By MAURA LERNER and JOSEPHINE MARCOTTY / StarTribune

startribune.com  
updated 10:30 p.m. CT, Tues., March. 18, 2008

In what officials are calling a "tragic medical error," a surgical team removed the wrong kidney from a patient with kidney cancer last week at Methodist Hospital in St. Louis Park, the hospital disclosed Monday.

Officials said the error occurred weeks before the surgery, when the kidney on the wrong side was identified on the patient's medical charts as cancerous. The patient, who was not identified, was left with the cancerous kidney when the healthy one was removed.

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## St. Joe's fined in wrong-site surgery

by James T. Mulder / The Post-Standard

Tuesday September 16, 2008, 8:41 PM

SYRACUSE, NY -- The state has fined St. Joseph's Hospital Health Center \$6,000 for operating on the wrong hip of a patient.

A patient with a fractured right hip had multiple fixation screws mistakenly inserted into his left hip, according to the state Health Department. After the error was discovered in the recovery room, hospital staff did the operation again on the correct hip.

The Syracuse hospital agreed to pay the fine as part of a settlement reached in May with the health department. The state recently posted information about the case on its hospital profile Web site, [hospitals.nyhealth.gov](http://hospitals.nyhealth.gov).

Hospital spokeswoman Kerri Ganci declined to discuss the July 2007 case because the patient is suing.

## Man's Surgery Performed On The Wrong Ankle

(CBS) A Minnesota man is permanently disabled because of a medical mistake at a Twin Cities hospital when a surgeon operated on the wrong body part. Surgical mistakes like that happened more than 200 times in Minnesota over the last five years.

"In 2008, this is one of those things that really just should not happen," said the patient's attorney Reid Rischmiller.

After years of pain from a warehouse work injury, a 57-year old Minneapolis man, who didn't want to be identified, decided to let doctors fuse his right ankle solidly together. His surgeon even signed the ankle with permanent marker moments before the operation last month.

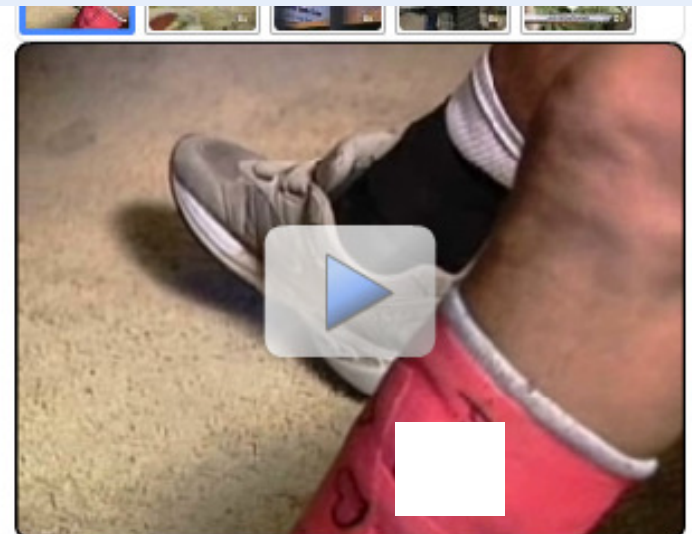
Yet still, the surgeon somehow, cut into and irreversibly locked together the bones in his healthy left ankle.

"We can't have this happen again. It's devastating for the patient and for our staff," said HealthEast Medical Director Robert Beck, M.D.

Beck is the medical director for all of HealthEast's Hospitals, including St. John's in Maplewood, Minn., where the operation took place. He said any one of the operating room staff could have spoken up and prevented the error.

"Over time people can get a little lax and we think that's probably what had happened," Beck said.

In reviewing this case, Beck said every person in that operating room did exactly what they were supposed to do according to safety procedures. And yet, he said, they didn't take those



### FEATURED STORY

Man's Surgery Performed On The Wrong Ankle  
Oct. 22, 2008, 10:16 p.m. CT

[Health Watch](#)

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Friday, October 24, 2008

## Wrong kidney removed despite concern of parents

SURGERY WHICH resulted in a child having the wrong kidney removed at Our Lady's Hospital for Sick Children in Crumlin, Dublin, proceeded despite concerns being raised by the child's parents about the side of the body on which the operation was being performed, an independent investigation has found, writes **Eithne Donnellan**, Health Correspondent.

It also found a whole series of factors resulted in the child having a healthy kidney removed last spring, to be left with a poorly functioning one.

There were no X-ray images reviewed at several stages in the process: when the child was listed for surgery in outpatients; when the child was admitted to hospital the day before surgery; on the pre-operative morning ward round on the day of surgery; in response to queries from parents about the operation side; or in theatre prior to making the incision.

### In this section »

- ▼ [Garda welcome use of pepper spray](#)
- ▼ [Accused said 'it was me', garda tells court](#)

## Holes drilled in the wrong side of heads during surgery NHS watchdog warns

Surgeons are drilling holes in the wrong side of people's heads during brain surgery despite a warning issued three years ago.

by Rebecca Smith, Medical Editor

Last Updated: 10:56PM GMT 21 Nov 2008

T Text Size + -

So-called wrong site surgery has been a consistent problem in the NHS and in some cases patients have died as result of having the wrong organ removed.

In 2005 the National Patient Safety Agency issued an alert to all neurosurgical units after an audit found there was no standard method of identifying which side the patient was to have surgery with some units marking with pen the side to be operated on and others marking the side not to.

Since the alert the NPSA have had another 15 reports of incidents in nine of the 36 neuro centres where surgeons have begun brain surgery on the wrong side of the head.

Another alert has now been issued saying it is still a problem.

The brain surgery incidents are among 56 wrong site surgical mistakes reported to the NPSA during 2007 and another 654 reports related to operating list errors where the wrong patient or the wrong operation had been planned.



# What Happens When Public Stakeholders Get Impatient?

- ▶ They make laws
  - Legislatures and MRSA
  - Washington State legislator (Feb 2009):  
“If hospitals won’t take meaningful steps to stop drug-resistant infections, then we’ll pass legislation to make sure they do.”
- ▶ Science is only one voice among many in the legislative process



# How Can We Do Much Better?

- ▶ Our goal must be to achieve major, durable improvement consistently
- ▶ A little better is not good enough
- ▶ We must document improvement
- ▶ Major barriers are:
  - 1) Lack of capacity to execute robust process improvement
  - 2) Health care organizations have not uniformly established a safety culture



# Robust Process Improvement

- ▶ Systematic approaches to problem solving proven in many other spheres of work
  - Lean, six sigma, change acceleration, Toyota
  - Different from what came before (CQI, TQM)
- ▶ Equally effective when applied to our toughest safety and quality problems
- ▶ Directly address critical failings of current QI
- ▶ Appealing to physicians and other clinicians

# How Have Others Done It?

- ▶ “High reliability organizations” are those that manage serious hazards extremely well
- ▶ HROs have certain common characteristics: a set of operating and management principles and tools and a particular culture
- ▶ Weick: “Safety is a dynamic non-event.”
- ▶ Getting to high reliability will be a long road
- ▶ Robust process improvement will be a vitally important vehicle for getting there





# Robust Process Improvement

Five essential steps ( = “DMAIC” )

- 1) Specify the improvement target
- 2) Measure the size of the problem
- 3) Identify specific causes
- 4) Target interventions to most important, modifiable causes
- 5) Embed intervention into routine work



# Recurring Lessons

- ▶ Must understand specific causes of the problem you're trying to fix
- ▶ Target interventions to those causes
- ▶ Solutions developed elsewhere may not work for you
- ▶ Sustaining improvement is difficult; requires monitoring and feedback

# Technical Solution is Not Enough

- ▶ Why does improvement so often fail?
  - Sometimes: technical solution is lacking
  - Most often: organization failed to accept and implement a good solution it had
- ▶ Robust Process Improvement (RPI) addresses this failing directly
- ▶ Change management is an essential component of effective improvement

# How to Sustain Improvement

Managing change is integral and must be explicitly included in improvement

$$E = Q \times A_1 \times A_2$$

Effectiveness (E) =

Technical quality (Q) x

Acceptance (A<sub>1</sub>) x

Accountability (A<sub>2</sub>)

# Robust Process Improvement at The Joint Commission

- ▶ The Joint Commission Enterprise is adopting these tools
  - Aggressive training program to build internal capacity to apply tools
  - Second full wave of training almost done
  - Goal is to embed these process improvement tools into TJC
- ▶ No plan to require health care organizations to adopt them



# The Joint Commission is Changing

- ▶ With our adoption of lean, six sigma, and change acceleration, we are rapidly changing our culture:
  - Focus on customers
  - Simplify our processes
  - Reduce our costs
- ▶ Project teams are now using RPI tools to address all these objectives throughout TJC

# What Does a “Focus on Customers” Mean for TJC?

- ▶ Pursuing our mission to help organizations help patients by improving quality and safety
  - Does not mean we make surveys easy
  - Does mean we deliver all of our improvement messages positively, creating a learning, not a punitive environment
- ▶ Dramatically increased learning from customers
- ▶ Using this feedback directly to inform our RPI


# Culture Begins With Leadership

- Worked with TJC Board to update our mission statement: adopted Aug 7, 2009

*To continuously improve health care for the public, in collaboration with other stakeholders, by evaluating health care organizations and inspiring them to excel in providing safe and effective care of the highest quality and value*



# Recent Customer Comments



“This was the most thorough and professional team I have ever encountered. The team leader has a passion for the process as an educational tool and truly inspires you to want to be better at what you do. While exhausted (truly) after the week, I am also inspired...and I am a hard sell.”

Director, perioperative services  
Northeast academic medical center



# Don't Just Talk the Talk

by Nicole Adrian,  
contributing editor


## In 50 Words Or Less

- The Joint Commission recently looked inward to improve processes and customer service.
- The improvement process started with five internal projects and a Green and Black Belt training program.
- The organization understands the importance of applying tools and ideas in-house that it promotes externally.



The Joint Commission  
tackles **its own**  
**processes** with lean  
and Six Sigma

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# Using RPI to Address Major Safety and Quality Problems

- ▶ TJC collaborating with MD and hospital leaders where lean, six sigma are working
- ▶ Use RPI tools with teams from several hospitals to develop and prove interventions
  - Identify key causes of failures
  - Tie interventions to those causes
- ▶ TJC to build knowledge base and spread to other organizations without RPI expertise

# Center for Transforming Healthcare



The screenshot shows the homepage of the Center for Transforming Healthcare. At the top left is the logo for the Joint Commission Center for Transforming Healthcare, featuring a stylized cross made of four colored squares (green, blue, yellow, and white). To the right of the logo is the text "Joint Commission Center for Transforming Healthcare" and the tagline "Creating Solutions for High Reliability Health Care". In the top right corner, there are navigation links for "INCREASE TEXT" (with A+ and -A icons), "PARTICIPANTS' LOGIN" (with a GO button), and a "SEARCH" input field. Below the header is a dark blue navigation bar with links for "About Us", "Participants", "Projects", "Solutions", "Sponsors", "Newsroom", and "Contact Us". The main content area is divided into several sections. On the left, a large blue banner reads "Welcome to... Joint Commission Center for Transforming Healthcare" and features a photo of a smiling female healthcare professional. Below the banner is a row of numbered tabs from 1 to 8, with tab 1 highlighted. To the right of the banner are three featured content boxes: "Featured Sponsor" for the American Hospital Association in Chicago, IL; "Featured Project" for "Increasing Hand Hygiene Protocol Usage" with a photo of hands being washed; and "Featured Participant" for Cedars-Sinai Medical Center in Los Angeles, CA. At the bottom left, there is a "Featured News" section. At the bottom right, there is a "Quick Links" section with three links: "The Joint Commission", "Joint Commission Resources", and "Joint Commission International".

**Joint Commission Center for Transforming Healthcare**  
*Creating Solutions for High Reliability Health Care*

INCREASE TEXT A+ -A

PARTICIPANTS' LOGIN GO

SEARCH

About Us Participants Projects Solutions Sponsors Newsroom Contact Us

**Welcome to...**  
**Joint Commission Center for Transforming Healthcare**

1 2 3 4 5 6 7 8

**Featured News**

**Quick Links**  
[The Joint Commission](#)  
[Joint Commission Resources](#)  
[Joint Commission International](#)

**Featured Sponsor**  
  
**American Hospital Association**  
**Chicago, IL**

**Featured Project**  
  
**Increasing Hand Hygiene Protocol Usage**

**Featured Participant**  
  
**Cedars-Sinai Medical Center**  
**Los Angeles, CA**

[www.centerfortransforminghealthcare.org](http://www.centerfortransforminghealthcare.org)

# Participating Hospitals

- ▶ Cedars-Sinai
- ▶ Exempla
- ▶ Fairview
- ▶ Froedtert
- ▶ Johns Hopkins
- ▶ Intermountain
- ▶ Kaiser-Permanente
- ▶ Mayo Clinic
- ▶ Memorial Hermann
- ▶ NY-Presbyterian
- ▶ North Carolina Baptist
- ▶ North Shore-LIJ
- ▶ Partners HealthCare
- ▶ Stanford Hospital
- ▶ Trinity Health
- ▶ Virtua

# Center for Transforming Healthcare

Directly responds to voice of our customers

▶ Raising outside funding support

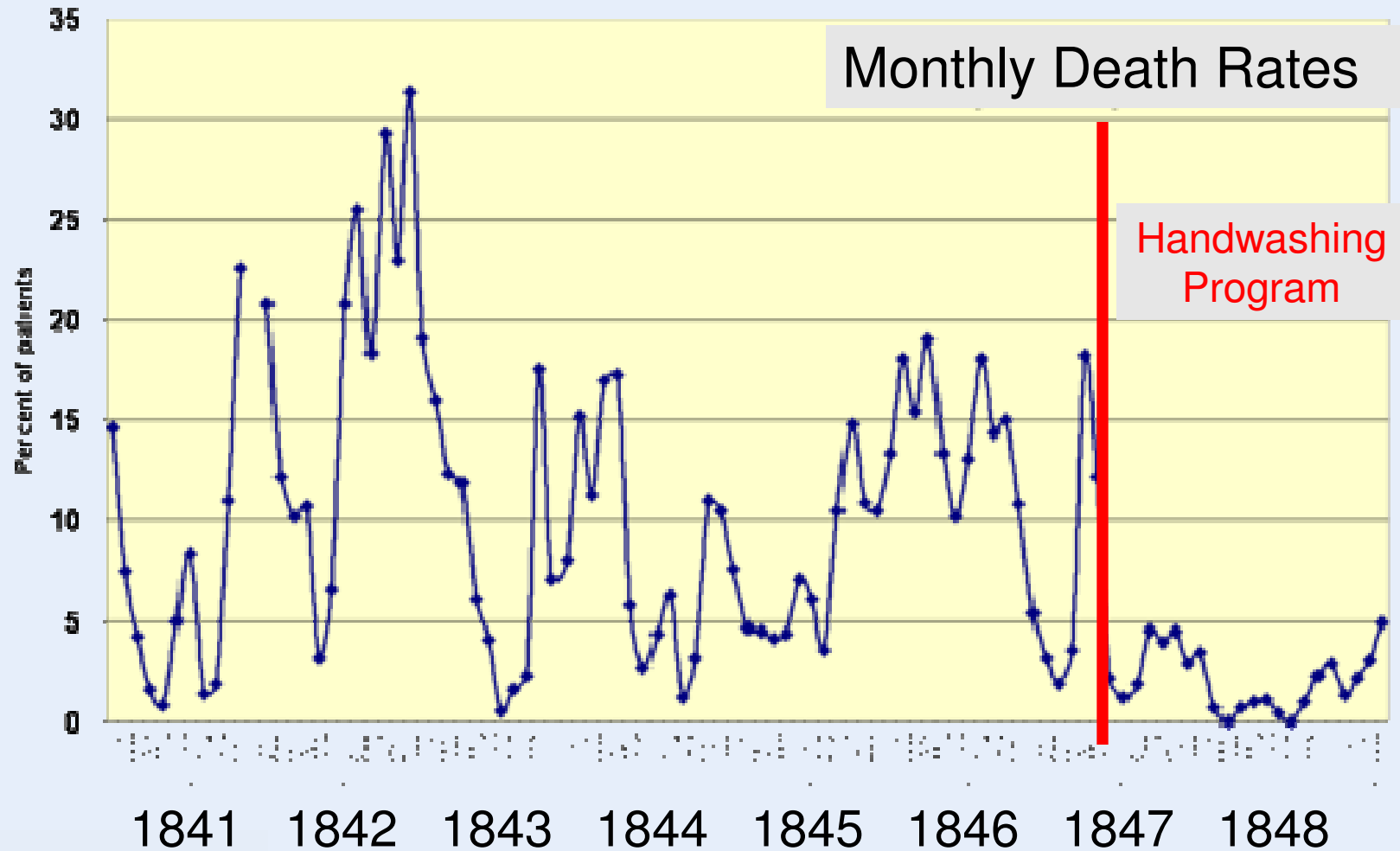
- TJC: \$10M
- 5 organizations have made major commitments: AHA, BD, Ecolab, GE, J&J
- Aim to deliver interventions to hospitals as part of accreditation; no added cost

▶ 1st project: early results

▶ 2<sup>nd</sup> project begun: hand-off communications

▶ Launched publicly last month

# Semmelweis' Original Data



# Many Important Causes

1. Faulty data on performance
2. Inconvenient location of sinks or hand gel dispensers
3. Hands full
4. Ineffective education of caregivers
5. Lack of accountability

➔ Each requires a very different strategy to eliminate



# Causes Differ by Hospital

Main Causes of Failure to Clean Hands (across all participating hospitals)								
	A	B	C	D	E	F	G	H
Ineffective placement of dispensers or sinks		X		X	X		X	X
Hand hygiene compliance data are not collected or reported accurately or frequently	X	X		X	X			X
Lack of accountability and just-in-time coaching		X	X	X	X		X	X
Safety culture does not stress hand hygiene at all levels			X	X	X	X		X
Ineffective or insufficient education		X	X	X	X		X	
Hands full	X	X	X	X	X		X	
Wearing gloves interferes with process	X	X	X	X			X	
Perception that hand hygiene is not needed if wearing gloves	X		X	X	X		X	X
Health care workers forget	X	X		X			X	
Distractions	X	X				X	X	

Note that not all of the main causes of failure appear in every hospital. The chart above represents the validation of the root causes across hospitals. This underscores the importance of understanding hospital-specific root causes so that appropriate solutions can be targeted.



# Effective Hygiene is in Our HANDS

## Habit

- Always wash in and wash out upon entering/exiting a patient care area and before and after patient care
- Make washing hands a habit – as automatic as looking both ways when you cross the street or fastening your seat belt when you get in your car

## Active Feedback

- Coach and intervene to remind staff to wash hands
- Clearly state expectations about when to sanitize hands to all staff members
- Communicate frequently – provide visible reminders and ongoing coaching to reinforce effective hand hygiene expectations
- Engage staff – real time performance feedback
- Tailor education in proper hand hygiene for specific disciplines
- Provide just-in-time training
- Use technology-based reminders and real time feedback
- Celebrate improved hand hygiene

## No One Excused

- Protect the patient and the environment – everyone must wash in and wash out
- Make it comfortable to wash hands with soap or use waterless hand sanitizer
- Identify proper hand hygiene as an organizational priority and performance expectation
- Hold everyone accountable and responsible – doctors, nurses, food service staff, housekeepers, chaplains, technicians, therapists
- Apply progressive discipline from the top – managers must hold everyone accountable for proper hand washing
- Commitment of leadership to achieve hand hygiene compliance of 90+ percent
- Serve as a role model by practicing proper hand hygiene

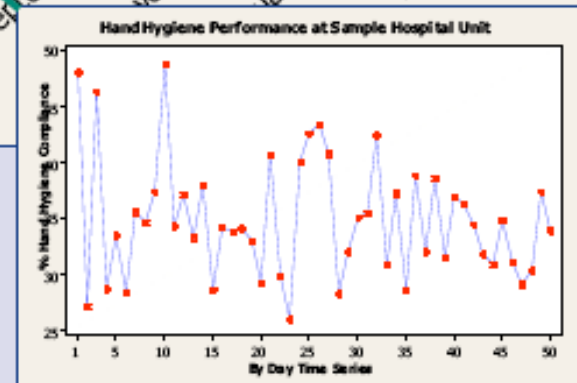
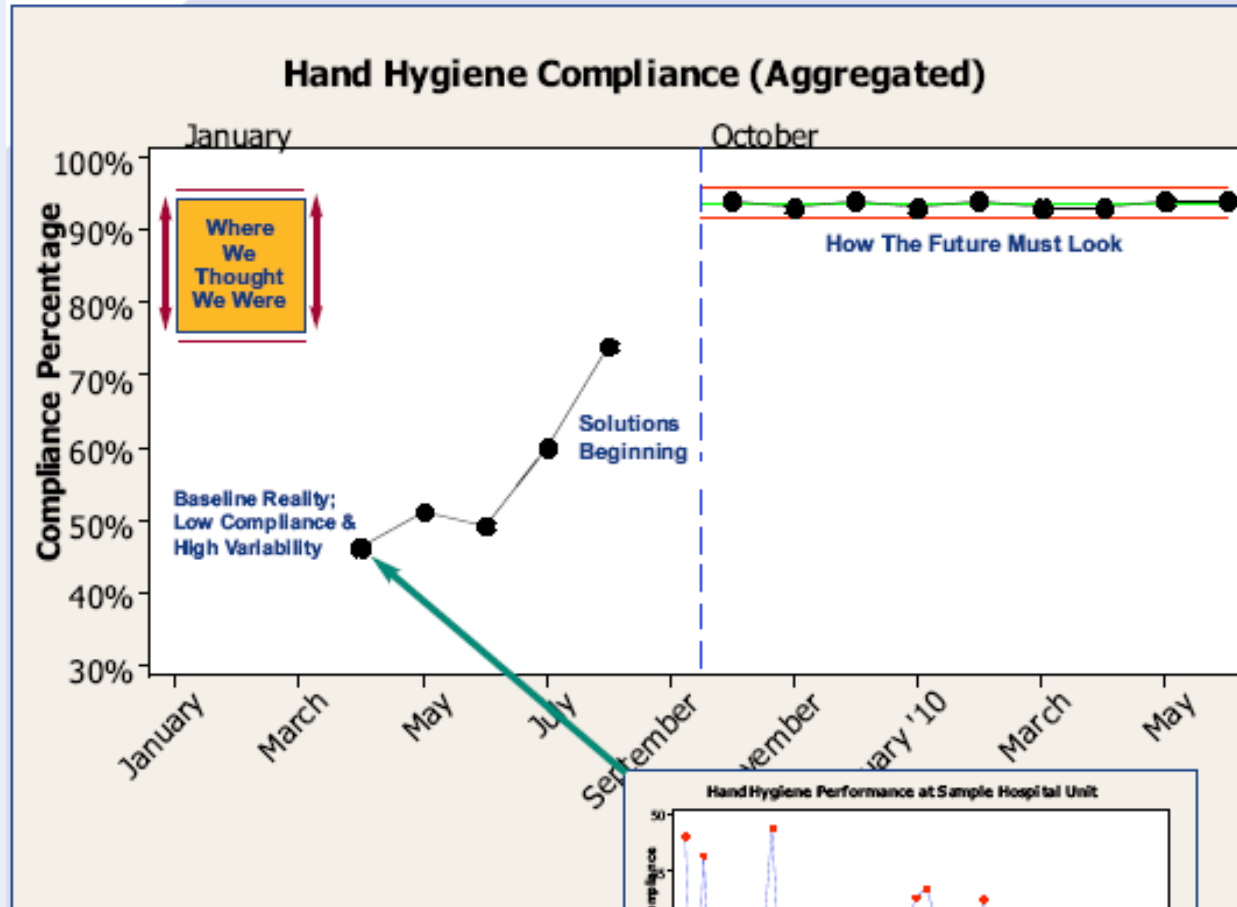
## Data Driven

- Data provide a framework for a systematic approach for improvement
- Utilize a sound measurement system to determine the real score in real time
- Use trained, certified independent observers to monitor appropriateness of hand hygiene
- Scrutinize and question the data
- Measure the specific, high-impact causes of hand hygiene failures in your facility and target solutions to those causes

## Systems

- Focus on the system, not just on people
- Make it easy; examine work flow of health care workers to ensure ease of washing hands:
  - Provide easy access of hand hygiene equipment and dispensers
  - Create a place for everything: for example, a health care worker with full hands needs a dedicated space where he or she can place items while washing hands
  - Limit entries and exits from a patient's room – make supplies available in room and eliminate false alarms that require staff to leave room to turn alarm off
- Identify new technologies to make it easy for staff to remember to wash hands, i.e. radio frequency identification, automatic reminders, warning systems, real time scoring

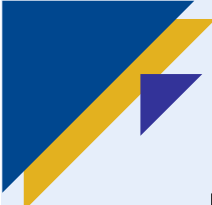
# Center Hand Hygiene Project



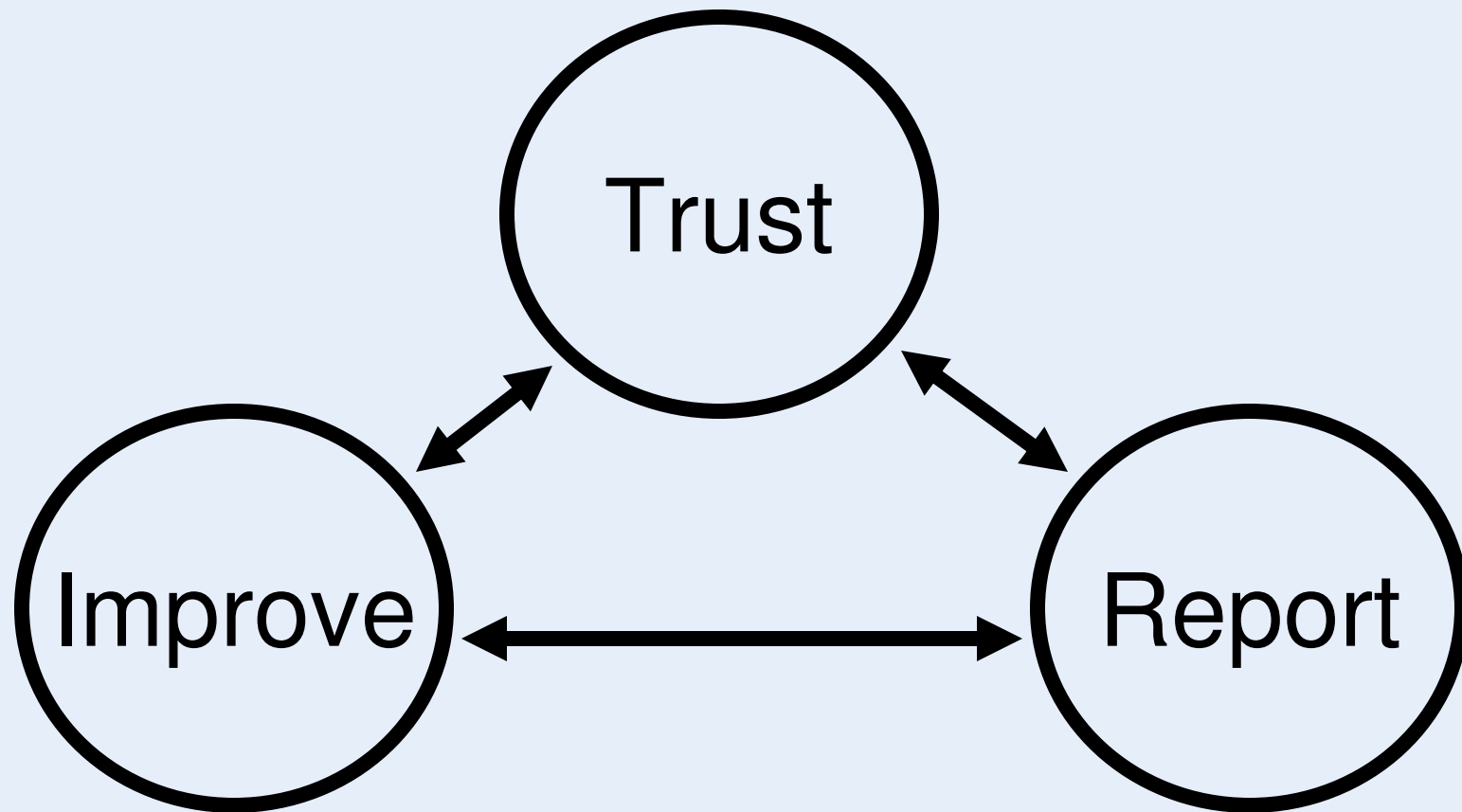
# How To Spread Improvement?

- ▶ To maximize impact, improvement knowledge must be able to reach hospitals of varying sizes and capabilities
- ▶ TJC will produce easy to use assessment tools for hospitals without RPI capacity
  - Measure process (e.g., hand hygiene)
  - Assess specific causes of failures
  - Match interventions to hospital's causes
- ▶ Engaging industry in Center projects

# Mechanisms For Spread

- 
- ▶ Benefiting accredited organizations at no additional cost
    - Surveyors communicating best practices
    - Web-based tool to guide organizations (measure, assess causes, solutions)
  - ▶ JCR products: publications, educational offerings, consulting programs
  - ▶ Peer-reviewed publications, trade press
  - ▶ Center web site

# The 3 Imperatives of a Safety Culture



# Imperative #1: Trust

- ▶ Aim is not a “blame-free” culture
- ▶ Safety culture separates small errors (for learning) from egregious ones (for discipline, equitably applied)
- ▶ Several standards for bad behavior often exist in big organizations
- ▶ Assess errors uniformly
- ▶ Establish one code of behavior

# Sentinel Event Alert on Intimidating Behaviors



The screenshot displays the website for The Joint Commission. At the top left is the logo, which consists of a stylized 'J' made of blue and yellow squares, followed by the text 'The Joint Commission'. To the right of the logo is a search bar with the word 'SEARCH' above it and a 'GO' button. Below the logo and search bar is a horizontal navigation menu with several buttons: 'ACCREDITATION PROGRAMS', 'CERTIFICATION PROGRAMS', 'STANDARDS', 'PATIENT SAFETY', 'SENTINEL EVENT' (highlighted in yellow), 'PUBLIC POLICY REPORTS', 'PERFORMANCE MEASUREMENT', 'LIBRARY', and 'ABOUT US'. Below the navigation menu is a breadcrumb trail: 'Home > Sentinel Event > Sentinel Event Alert'. On the left side of the page is a vertical sidebar menu with a 'Printer-Friendly' icon and the following items: 'Advisory Group', 'Forms and Tools', 'Policy and Procedures', 'Reporting Alternatives', 'Sentinel Event Alert', and 'Statistics'. The main content area features a dark blue header with the text 'Sentinel Event Alert'. Below this header, the text reads 'Issue 40, July 9, 2008' followed by the title 'Behaviors that undermine a culture of safety'. The main body of text states: 'Intimidating and disruptive behaviors can foster medical errors,(1,2,3) contribute to poor patient satisfaction and to preventable adverse outcomes,(1,4,5) increase the cost of care,(4,5) and cause qualified clinicians, administrators and managers to seek new positions in more professional environments. (1,6) Safety and quality of patient care is dependent on teamwork, communication, and a collaborative work environment. To assure quality and to promote a culture of safety, health care organizations must address the problem of behaviors that threaten the performance of the health care team.'



# Not Only “Disruptive Physicians”

- ▶ ISMP “Workplace Intimidation Survey” documented high frequency behaviors
  - Ignoring pages or phone calls
  - Condescension, impatience with questions
- ▶ Physicians and others engage in them
- ▶ These behaviors destroy trust and stifle reporting of unsafe situations and behaviors
- ▶ TJC Code of behavior aimed at these, too

# The Joint Commission Today

- ▶ Continuing to aggressively improve standards and survey process
  - Increasing the connection between our requirements and evidence of impact
  - Focusing surveys on most important patient safety and quality risks
- ▶ Negotiate with CMS: nurse protocols
- ▶ New Center uses robust process improvement to deliver effective solutions



# The Big Challenge

Can we transform health care into a high-reliability industry---with rates of adverse events and breakdowns in safety processes comparable to the best high reliability organizations in the world?