7th Yearly Conference of Lebanese Society for Quality and Safety in Healthcare

Paula Wilson, CEO

Getting to Zero Harm

August 31, 2019

Joint Commission International

Mission of Joint Commission International

To improve the **safety and quality** of care in the international community through the provision of education, publications, consultation, evaluation, and accreditation services.

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JCI Accreditation Global Footprint

August 1, 2019

71 Countries

1030 Accredited Organizations

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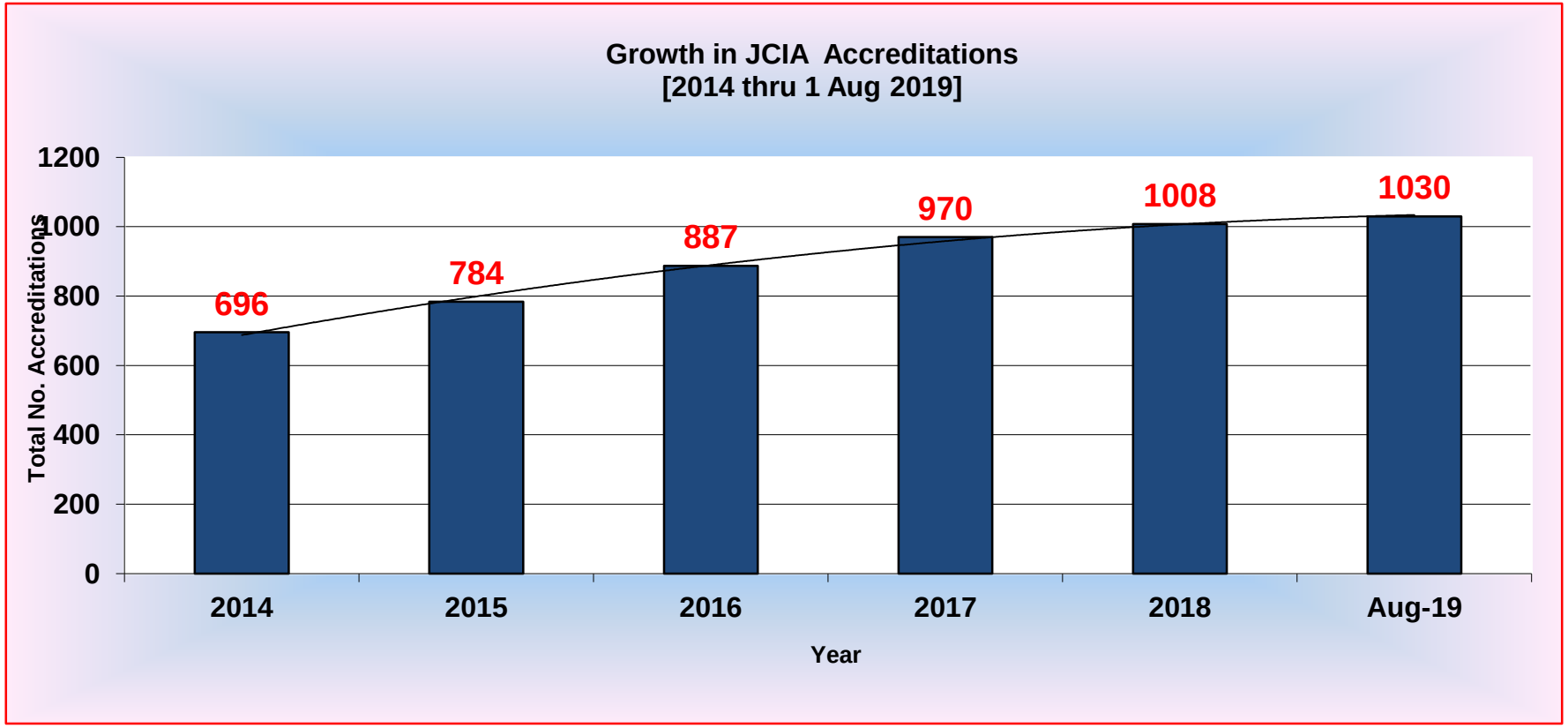
Global Accredited Organization Growth



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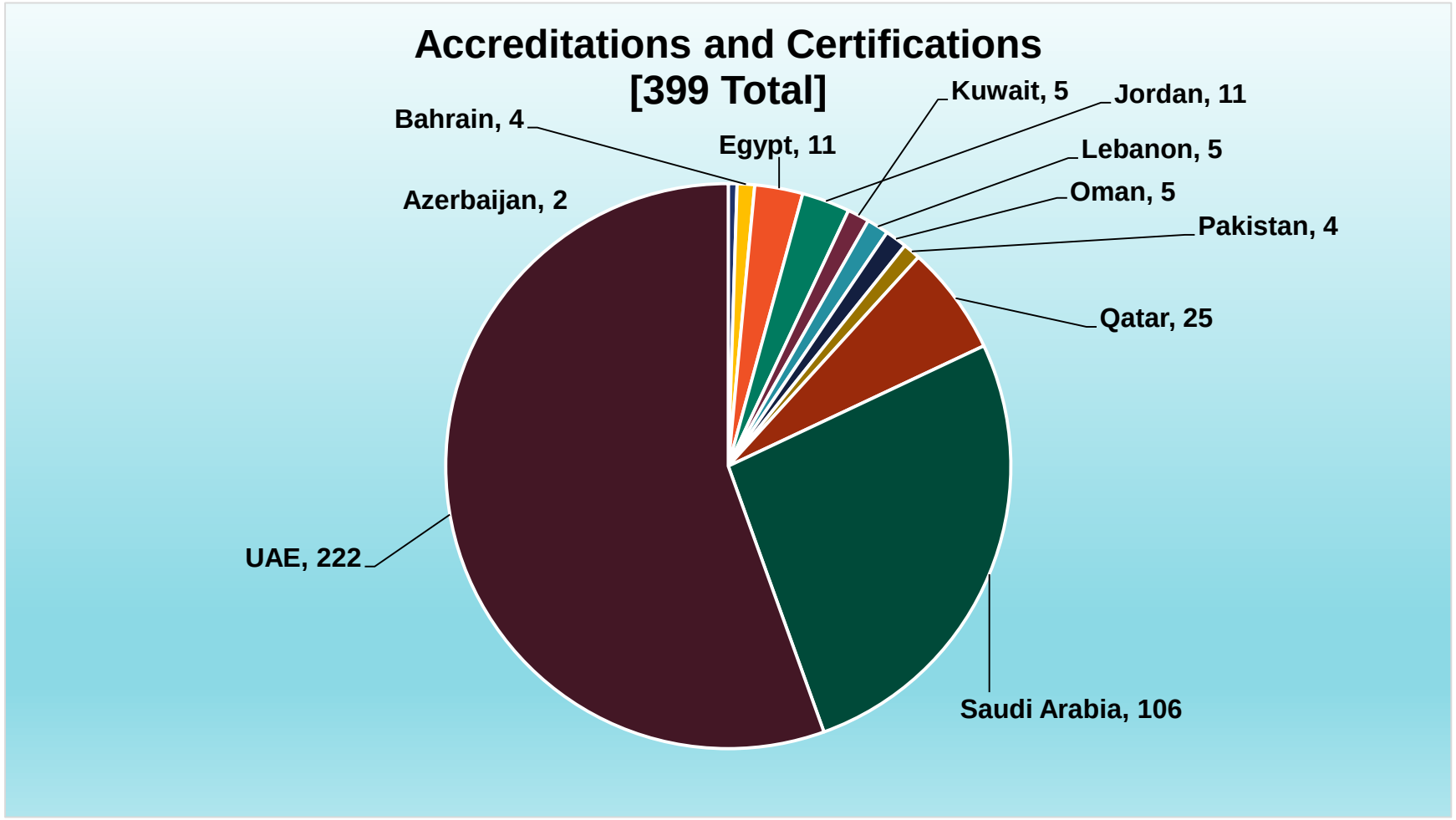
Middle East – August 1, 2019



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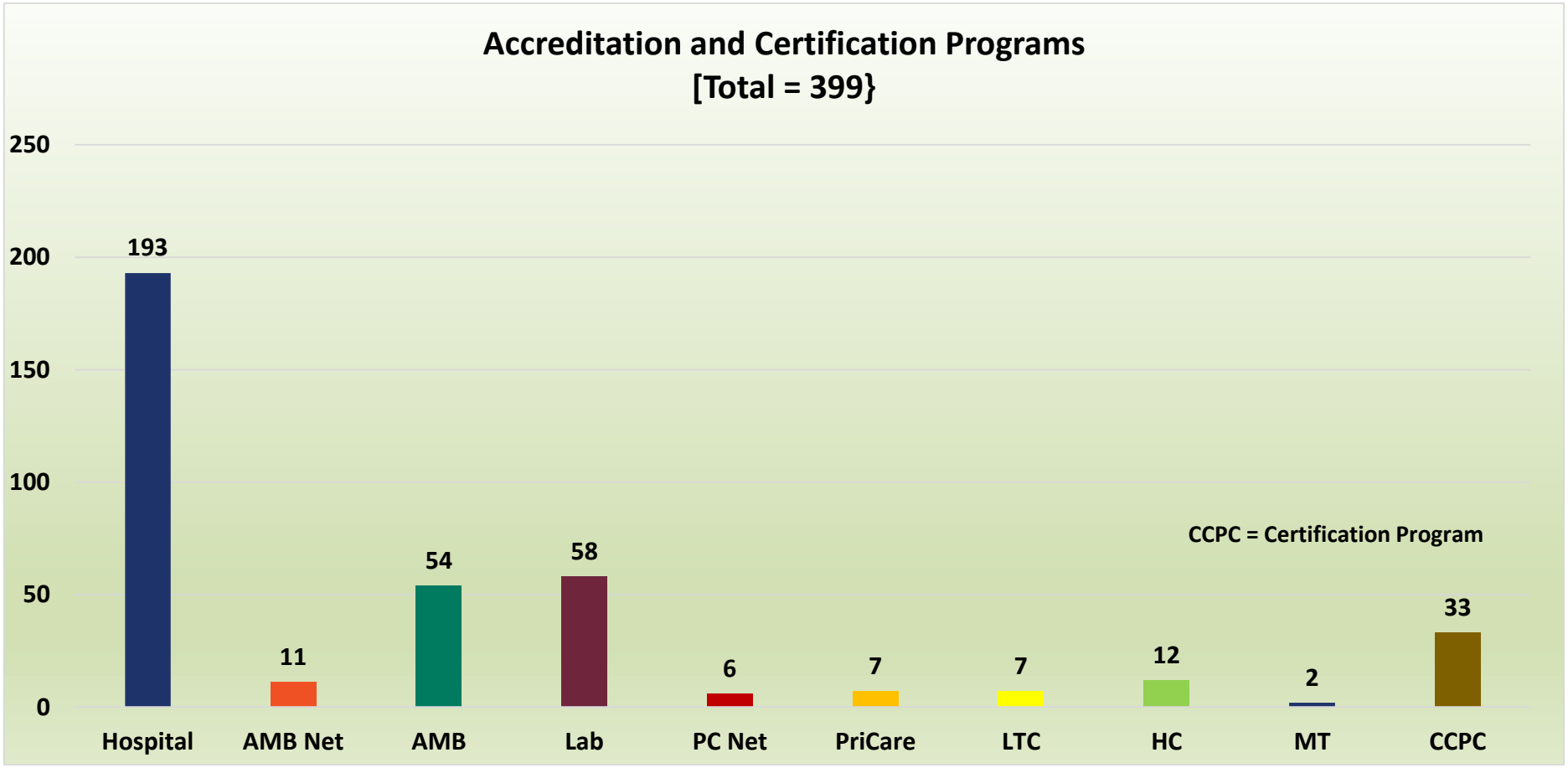
JCI Accreditations/Certification – Middle East



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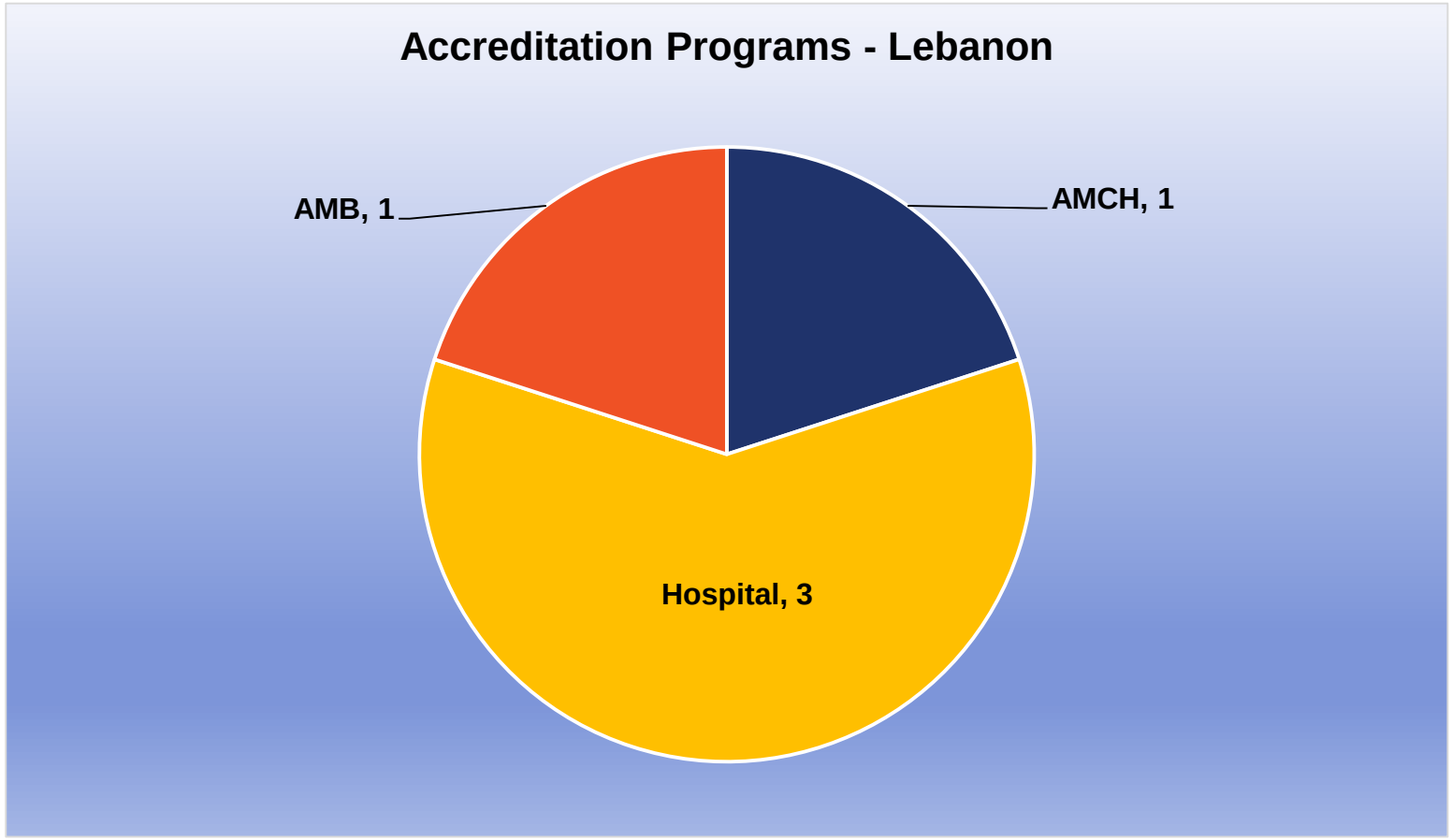
JCI Accreditations by Program – Lebanon



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Getting to Zero Harm

Current State of Quality

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

- Uncommon, preventable adverse events
  - Surgery on wrong patient or body part
  - Fires in ORs, retained foreign objects
  - Infant abductions, inpatient suicides

High Reliability Organizations

- High reliability is the consistent performance at high levels of safety over long periods of time (Chassin, Loeb 2011)
- Nuclear power, aviation, petroleum and chemical industries, aircraft carriers, wildfire fighting, space flight
  - Where failure to perform can mean the death of some or all of the team

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Traits of HROs

- Believe anything can and will go wrong (engineers) vs. nothing will go wrong (medical)
- Focus is on reliability
- It is a mindset and a culture
- The state of high reliability is never complete or perfect

More HRO Traits

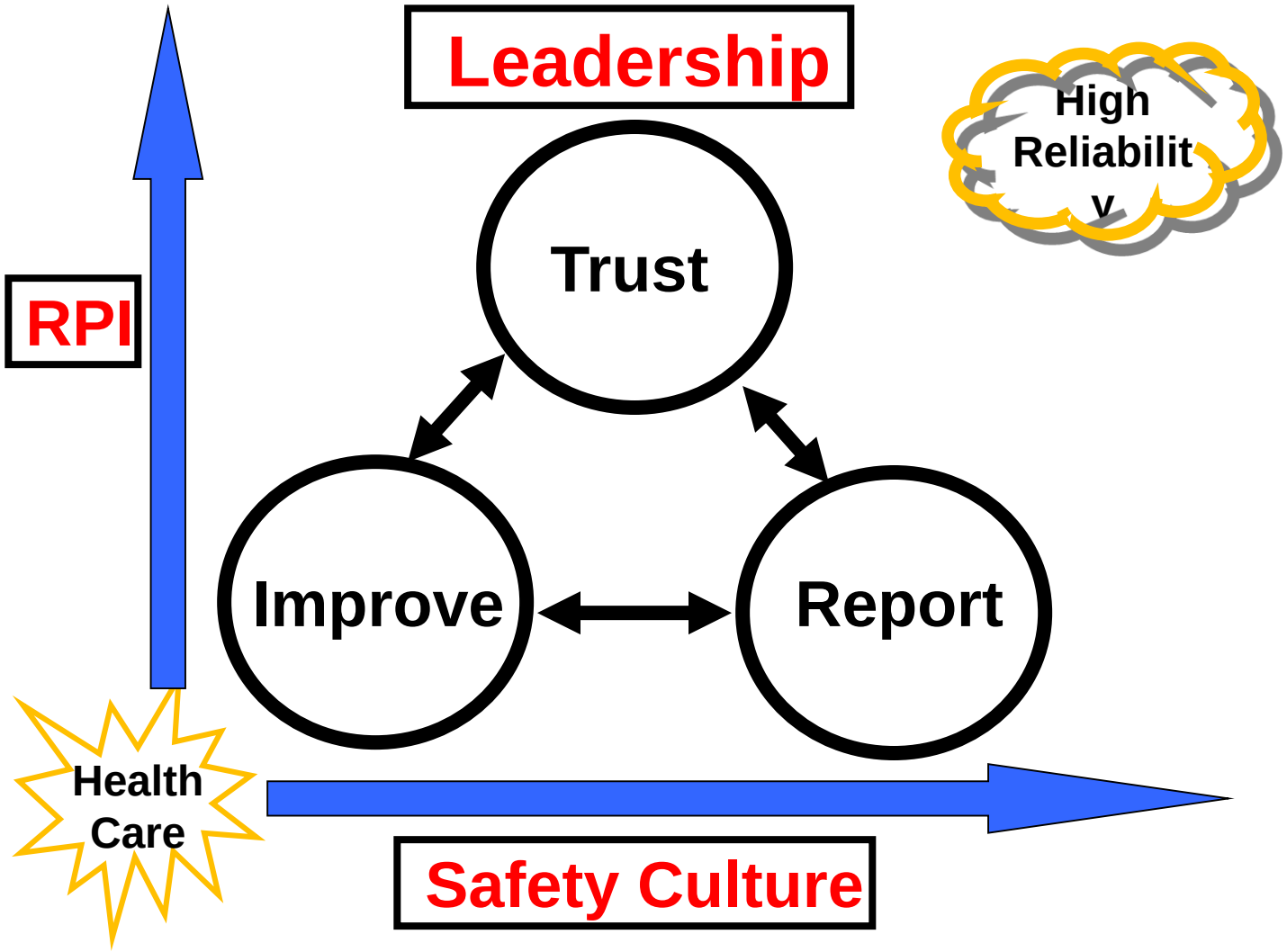
- HROs seek to know what they do not know
- They aggressively avoid organizational hubris
- They design redundant systems
- They proactively share learning and information throughout the organization
  - They break down the silos

HRO Traits continued

- It is NOT:
  - A consensus culture
  - An organization focused on success
  - An organization focused on hierarchy
- High Reliability in health care:
  - Very limited experience
  - The path to success not clear
  - But some organizations are striving

Crucial Elements of High Reliability

- Leadership
  - Board, CEO, other leaders
- Safety Culture
- Robust Process Improvement
  - Understand the methods, train staff



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Leadership

- Leader commitment is essential
- The leader must:
  - Understand the how and why of current operations, systems
  - Create a vision for the desired state
  - Be disciplined to sustain change
  - Commit to own growth and learning
  - Walk in the patient experience
  - Create an environment for tough questions
- Leadership and cues

A Safe and Just Culture

- Components of a safe culture:
  - Trust
  - Transparency and reporting
  - Improvement
- A Just Culture
  - Blameless errors versus blameworthy errors
  - Fairness key here

Robust Process Improvement

- Lean
  - Eliminate waste
- Six Sigma
  - Reduce defaults
- Change Management
  - Key component: WIIFM

Why Is Safety Culture So Important?

- Patients
  - They should not have to worry
- The Business Case
  - Errors are costly; payers are pushing back
- A safe culture is the feedback loop for constantly improving

Leaders and Safety Culture

The high performing health care leader recognizes the importance of creating and sustaining a safe culture.

What is Meant by Blame Free?

- Need a clear blame free policy :
  - Employees not blamed for honest mistakes or errors in judgment
  - Critical to have near misses reported regularly – you need to create an environment where everyone feels safe making these reports
  - You can’t fix a problem you do not know exists

What is a Just Culture?

- Understands difference between and among:
  - Human error: interruptions, distractions, multitasking
  - At-risk behavior: complacency
  - Reckless behavior: incompetence, substance abuse
- Response is not related to severity of the error or whether there was harm to the patient

Human Error Versus Systems Error

- Too much focus on human element
- Root cause analysis, failure mode and effects analysis
- Determine human error or systems error
- Most errors result from bad systems

Key features of a safety culture program

- Acknowledges high-risk nature of hospital's activities
- Individuals are able to report errors or near misses without fear of reprimand or punishment;
- Collaboration across ranks and disciplines to seek solutions to patient safety problems; and
- Committed staff time, education, a safe method for reporting issues, etc., to address safety concerns.

JCI Safety Culture Standards Compliance

- Have a patient safety plan
- Develop an annual report card
- Have a patient safety committee
- Educate all staff – near miss is an error
  - Do we agree?
- Engage the board
- Engage the medical staff

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Safety Culture Standards Compliance

- Support employees when there is an event
- Hold all team members accountable for modeling desirable behaviors
- Develop organizational process to address intimidating and disruptive behaviors

Leadership's Role

- Monitor compliance with the safety culture standards
- Provide people and other resources
- Spend time on this; make it clear this is a priority
- Coach, inspire, communicate, motivate; a good CEO is acutely aware of the risks involved and is not irrationally optimistic that everything is ok
- Leaders give the signals on safety culture

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