Patient First
Operational Responsibility

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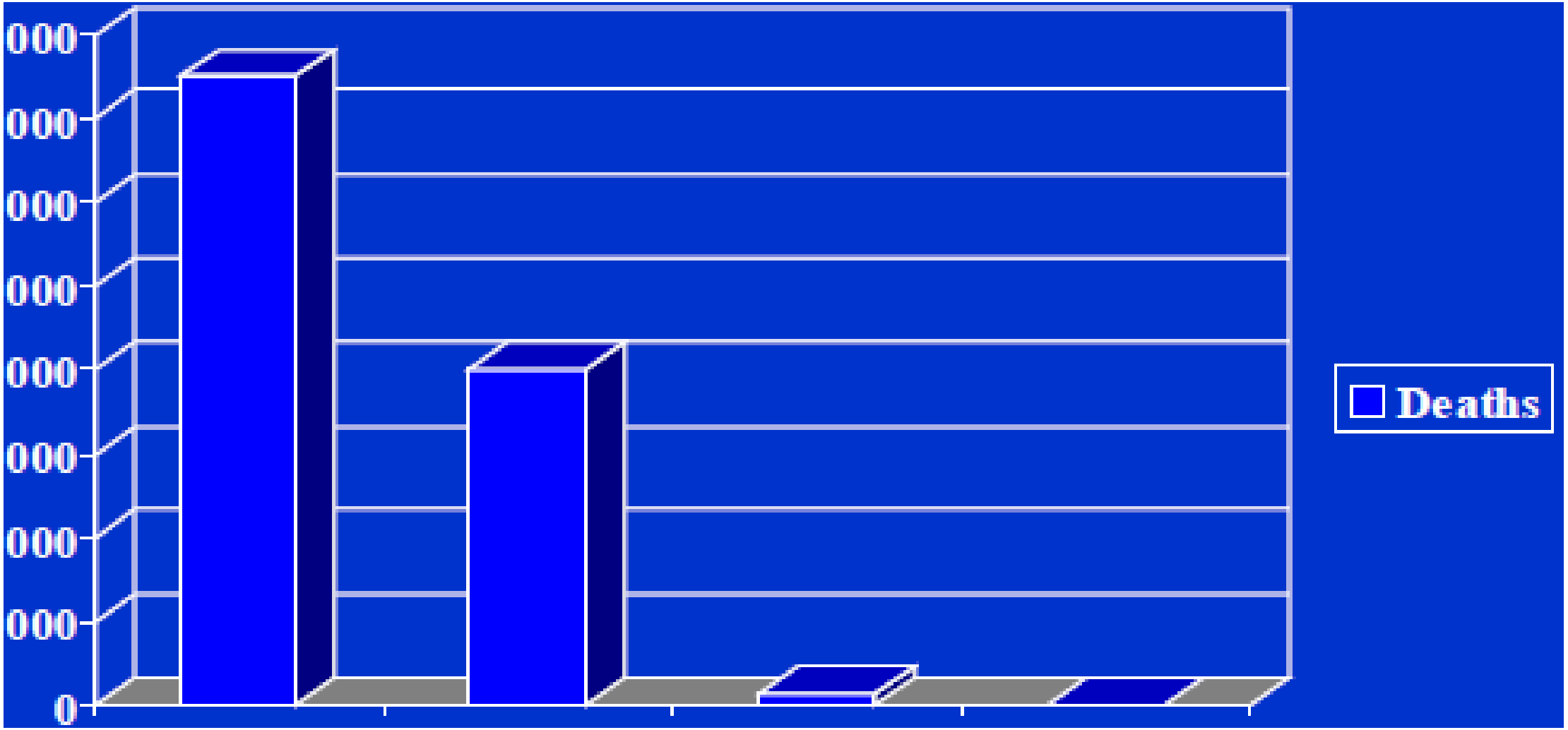
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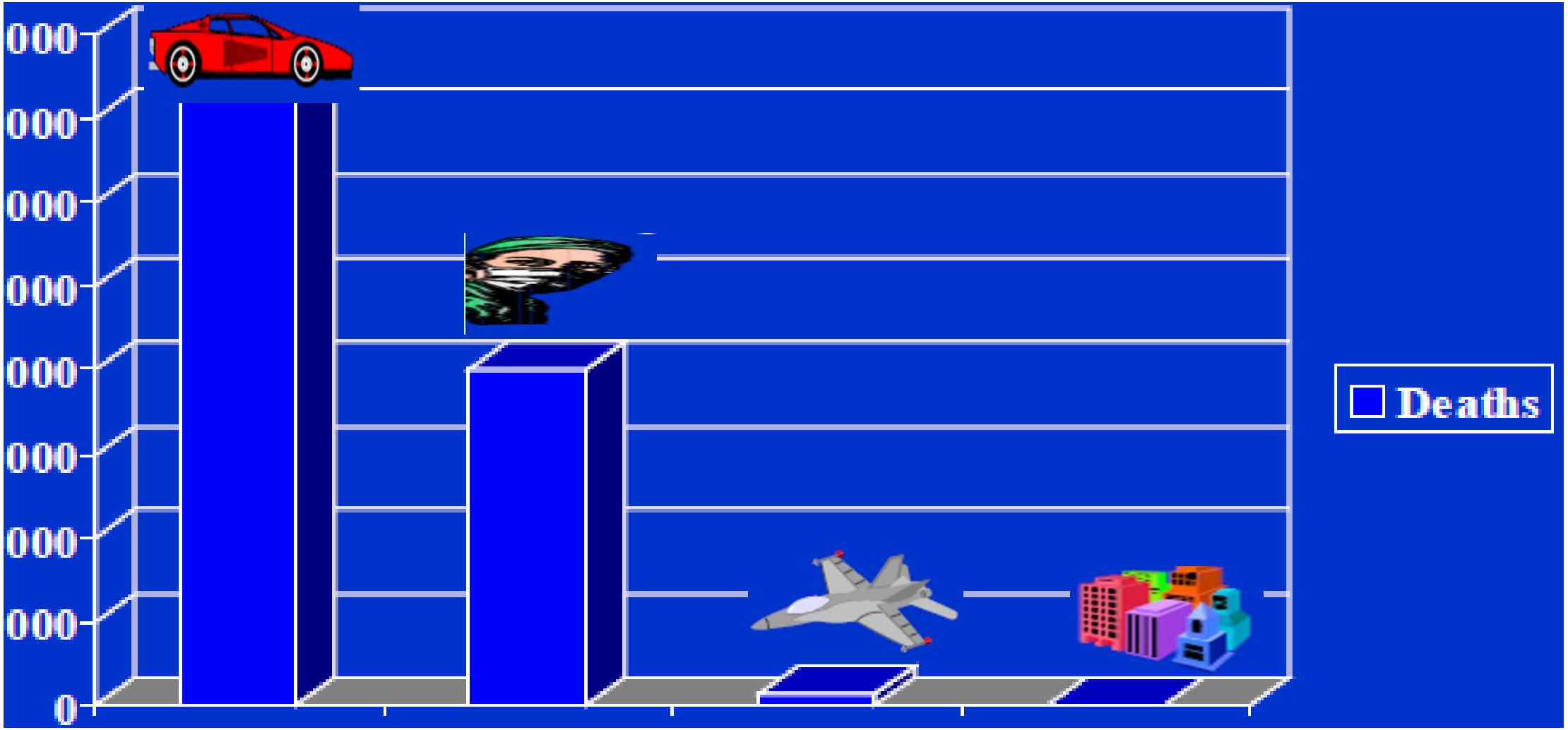
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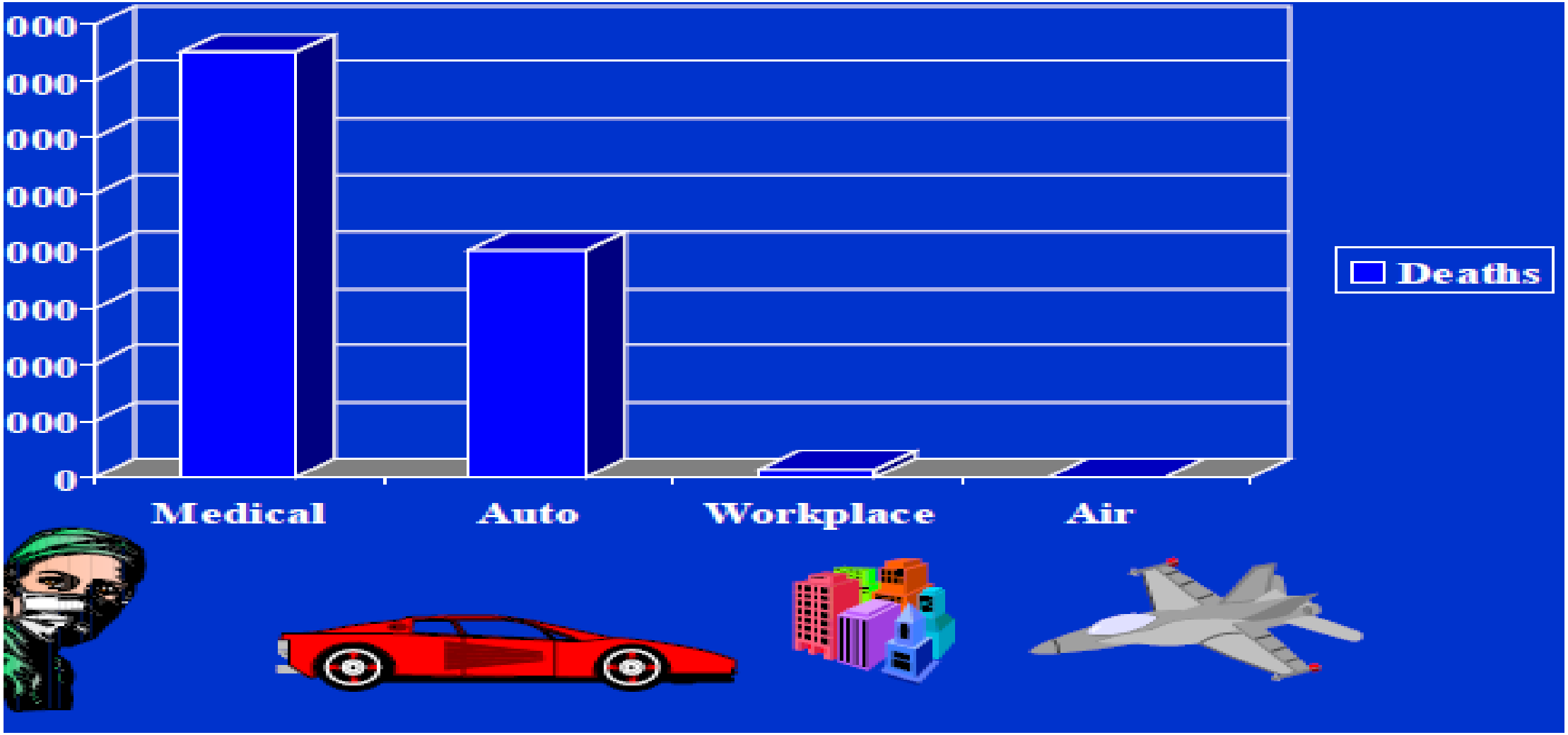
Those who care the most…… Cause the most



Black Box

As the transformation places the patient in the center of the healthcare system,

it is imperative for the 2020 providers to forge partnership with accrediting bodies and institutions and integrate the process into the daily experience of the system,

and most importantly

<u>the daily experience of the patient.</u>

Continuous Readiness

to create and maintain an environment of

Patient safety

Operational Myths

Patient centered Care

MYTH #1: PROVIDING PATIENT-CENTERED CARE IS TOO COSTLY.

Operational Myths

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MYTH #7: MANY PATIENT-CENTERED PRACTICES COMPROMISE INFECTION CONTROL EFFORTS, AND THEREFORE, CANNOT BE IMPLEMENTED.

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- Constant Readiness
  It cant Happen By Default…….?

- Hospital leaders Claim / Need to:

  - Understand what a state of readiness for patient safety and patient centered care looks like

  - Create the structure and activities that will allow the organization to achieve it and maintain it.

  - Be Accountable

Quality Plan, Focus & Incentives

JC. Journal. Quality & Patient Safety

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1195 RCA Summaries Reported by JCAHO

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- 63% orientation/training
- 56% communication
- 50% patient assessment process
- 43% physical environment
- 35% information availability
- 28% staff competency/credentialing
- 26% equipment factors
- 23% staffing levels
- 18% storage/access issues

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Operational Responsibility

Administrative, Financial & Clinical


IF IT GETS MUCH WORSE WE MAY BE FORCED TO MAKE RELIABLE PRODUCTS AND PROVIDE GOOD CUSTOMER SERVICE!

Operational Responsibility

Patient First

does not look like this

- Your hospital isn't analyzing data, or staff isn't knowledgeable of results
- Your team isn't familiar with the quality and safety goals, or the hospital's efforts
- Workers see only their own department's function; they're not aware of the hospital as a whole
- They don't know the standards Regulations language
- Staff members aren't cognizant of changes in regulations; they don't understand why procedures change

If it does…… Read this

A man is flying in a hot air balloon and realizes he is lost. He reduces height and spots a man down below. He lowers the balloon further and shouts: "Excuse me, can you tell me where I am?"

The man below says: "Yes, you're in a hot air balloon, hovering 30 feet above this field."

"You must work in Information Technology," says the balloonist.

"I do," replies the man. "How did you know?"

"Well" says the balloonist, "everything you have told me is technically correct, but it's of no use to anyone."

The man below says "You must be an executive."

"I am" replies the balloonist, "but how did you know?"

"Well," says the man, "you don't know where you are, or where you're going, but you expect me to be able to help. You're in the same position you were before we met, but now it's my fault."

Operational Responsibility
Administrative, Financial & Clinical

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looks like this

- Data are aggregated and analyzed
- Results of data analysis are communicated and acted on
- Committee structure is conducive to communication from leaders to line staff and back up the ladder
- Staff members are able to talk about patient safety and quality goals – and what the hospital is doing about them
- Staff are aware of the hospital as a whole, not only their niche, staff members are familiar with the regulations and standards

Operational Responsibility
Administrative, Financial & Clinical

Safe Patient Centered Care

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Operational Responsibility
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Operational Responsibility
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- **Availability of resources for providing care.**

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Operational Responsibility
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Seven Steps to Patient Safety

Step 1	Build a safety culture
Step 2	Lead and support your staff
Step 3	Integrate your risk management activity
Step 4	Promote reporting
Step 5	Involve and communicate with patients and the public
Step 6	Learn and share safety lessons
Step 7	Implement solutions to prevent harm

Operational Responsibility
Administrative, Financial & Clinical

Bottom / Top Operational Inquiries

- What happened? (event/near miss description, severity of actual or potential harm, people and equipment involved)
- Where did it happen? (location/speciality)
- When did it happen? (date and time)
- How did it happen? (immediate, or proximate cause(s))
- Why did it happen? (underlying, or root causes(s))
- What action was taken or proposed? (immediate and longer term)
- What impact did the event have? (harm to the organisation, the patient, others)
- What factors did, or could have, minimised the impact of the event?

Operational Responsibility
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Black Box

Standard

LD.010301 JCAHO

Rationale

Elements Of Performance

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Rationale

The governing body's ultimate responsibility for safety and quality derives from its legal responsibility and operational authority for hospital performance. In this context, the governing body provides for internal structures and resources, including staff that supports safety and quality.

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Rationale

Elements Of Performance

1. *The governing body defines in writing its responsibilities.*
2. *The governing body provides for organization management and planning.*
3. *The governing body approves the hospital's written scope of services.*
4. *The governing body selects the chief executive.*
5. *The governing body provides for the resources needed to maintain safe, quality care, treatment, and services.*
6. *The governing body works with the senior managers and leaders of the organized medical staff to annually evaluate the hospital's performance in relation to its mission, vision, and goals.*
7. *The governing body provides a system for resolving conflicts among individuals working in the hospital.*
8. *The governing body provides the organized medical staff with the opportunity to participate in governance.*
9. *The governing body provides the organized medical staff with the opportunity to be represented at governing body meetings (through attendance and voice) by one or more of its members, as selected by the organized medical staff.*
10. *Organized medical staff members are eligible for full membership in the hospital's governing body, unless legally prohibited.*

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Standard LD.03.01.01

Leaders create and maintain a culture of safety and quality throughout the hospital.

Rationale

Safety and quality thrive in an environment that supports teamwork and respect for other people, regardless of their position in the organization. Leaders demonstrate their commitment to quality and set expectations for those who work in the organization. Leaders evaluate the culture on a regular basis. Leaders encourage teamwork and create structures, processes, and programs that allow this positive culture to flourish. Disruptive behavior that intimidates others and affects morale or staff turnover can be harmful to patient care. Leaders must address disruptive behavior of individuals working at all levels of the organization, including management, clinical and administrative staff, licensed independent practitioners, and governing body members.

Elements of Performance

1. *Leaders regularly evaluate the culture of safety and quality using valid and reliable tools.*
2. *Leaders prioritize and implement changes identified by the evaluation.*
3. *Leaders provide opportunities for all individuals who work in the hospital to participate in safety and quality initiatives.*
4. *The hospital has a code of conduct that defines acceptable, disruptive, and inappropriate behaviors.*
5. *Leaders create and implement a process for managing disruptive and inappropriate behaviors.*
6. *Leaders provide education that focuses on safety and quality for all individuals.*
7. *Leaders establish a team approach among all staff at all levels.*
8. *All individuals who work in the hospital, including staff and licensed independent practitioners, are able to openly discuss issues of safety and quality.*
9. *Literature and advisories relevant to patient safety are available to all individuals who work in the hospital.*
10. *Leaders define how members of the population(s) served can help identify and manage issues of safety and quality within the hospital.*

Standard LD.04.04.05

The hospital has an organization-wide, integrated patient safety program.

Elements of Performance

1. *The hospital implements a hospital-wide patient safety program.*
2. *One or more qualified individuals or an interdisciplinary group manages the safety program.*
3. *The scope of the safety program includes the full range of safety issues, from potential or no harm errors (sometimes referred to as near misses, close calls, or good catches) to hazardous conditions and sentinel events.*
4. *All departments, programs, and services within the hospital participate in the safety program.*
5. *As part of the safety program, the hospital creates procedures for responding to system or process failures.*
6. *The hospital provides and encourages the use of systems for blame-free internal reporting of a system or process failure, or the results of a proactive risk assessment.*
7. *The hospital defines sentinel event and communicates this definition throughout the organization.*
8. *The hospital conducts thorough and credible root-cause analyses in response to sentinel events as described in the "Sentinel Events" chapter of this manual.*
9. *The hospital makes support systems available for staff members who have been involved in an adverse or sentinel event.*
10. *At least every 18 months, the hospital selects one high-risk process and conducts a proactive risk assessment.*
11. *To improve safety, the hospital analyzes and uses information about system or process failures and the results of proactive risk assessments.*
12. *The hospital disseminates lessons learned from root cause analyses, system or process failures, and the results of proactive risk assessments to all staff members who provide services for the specific situation.*
13. *At least once a year, the hospital provides governance with written reports on the following:*
    - *All system or process failures*
    - *The number and type of sentinel events*
    - *Whether the patients and the families were informed of the event*
    - *All actions taken to improve safety, both proactively and in response to actual occurrences*
14. *The hospital encourages external reporting of significant adverse events, including voluntary reporting programs in addition to mandatory programs.*

Patient Safety

Patient

Ali Elhaj, LLM., Ph. D.

Patient Safety

Freedom From Injury While Receiving Care

Patient

Ali Elhaj, LLM., Ph. D.

Safe Healthcare Environment

Patient

Ali Elhaj, LLM., Ph. D.

Safe Healthcare Environment

Clinical Care:

Patient

Ali Elhaj, LLM., Ph. D.

Safe Healthcare Environment

Clinical Care:

Managed & Measured

Patient

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Safe Healthcare Environment

Clinical Care:

Managed & Measured

Clinical Outcomes:

Patient

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Safe Healthcare Environment

Clinical Care:

Managed & Measured

Clinical Outcomes:

Achieved

Patient

Patient Safety

Freedom From Injury While Receiving Care

Safe Healthcare Environment

Clinical Care:

Managed & Measured

Clinical Outcomes:

Achieved

Patient

Presently: Fragmented Approach

Patient Safety

Freedom From Injury While Receiving Care

Safe Healthcare Environment

Clinical Care:

Managed & Measured

Clinical Outcomes:

Achieved

Patient

Presently: No Systematic Teamwork

Patient Safety

Freedom From Injury While Receiving Care

Safe Healthcare Environment

Clinical Care:

Managed & Measured

Clinical Outcomes:

Achieved

Patient

Replace: Fragmented Approach by Systematic Teamwork

Patient Safety

Freedom From Injury While Receiving Care

Safe Healthcare Environment

Clinical Care:

Managed & Measured

Clinical Outcomes:

Achieved

Patient

Replace: Fragmented Approach by Systematic Teamwork

Patient Safety

Freedom From Injury While Receiving Care

Safe Healthcare Environment

Clinical Care:

Managed & Measured

Clinical Outcomes:

Achieved

Involve the patient

Replace: Fragmented Approach by Systematic Teamwork

Patient Safety

Freedom From Injury While Receiving Care

Safe Healthcare Environment

Clinical Care:

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Clinical Outcomes:

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Involve the patient

Systematic Teamwork

Patient Safety

Freedom From Injury While Receiving Care

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Involve the patient