Transforming Your Vision into Reality:
Leadership, Safety Culture & Process Improvement

Mark Pelletier, RN, MS
Chief Operating Officer
Accreditation & Certification Operations &
Chief Nurse Executive
The Joint Commission

Ana Pujols McKee, MD
Executive Vice President &
Chief Medical Officer
The Joint Commission
If We Know These Facts & Have Known Them for Some Time –

What are we doing about it? WHAT ARE WE WAITING FOR?

The number of reported pregnancy-related deaths in the US steadily increased from

- 7.2 deaths per 100,000 live births in 1987
- to a high of 18.0 deaths per 100,000 live births in 2014

MODERN MEDICINE

The third-leading cause of death in US most doctors don't want you to know about

- More than 250,000 people in the US die every year from medical errors
- Medical errors are the third leading cause of death after heart disease and cancer

© 2018 Joint Commission Resources. All Rights Reserved.
Imagine a New NOW

Zero  – Patient harm events: falls, pressure ulcers, wrong-site surgery, OR fires, etc.

Zero  – Harm events for caregivers

Zero  – Episodes of no-benefit health care:
   – Imaging in simple back pain, Antibiotics for colds
Today is About How We Can Work Together on This Journey to Zero

The Importance of **LEADERSHIP**

**COMMITMENT**

to Quality and Safety
The Importance of LEADERSHIP COMMITMENT to Quality and Patient Safety

– Commitment to zero harm and high reliability –

The Center for Transforming Healthcare (CTH) can help

“...The road to high reliability is an ongoing journey. It’s a commitment to patient safety and the way we deliver quality health care.”

Mark Chassin, MD, FACP, MPP, MPH, President and Chief Executive Officer of The Joint Commission

Hand Hygiene
Hand-Off Communication
Safe Surgery
Preventing Falls
# The Importance of LEADERSHIP COMMITMENT to Quality and Patient Safety

## Engaging Physicians and Physician Leadership

### The Joint Commission Physician Resources

- **Website**: [jointcommission.org](https://jointcommission.org)
- **Home > Topics > Physicians**

<table>
<thead>
<tr>
<th>RESOURCE</th>
<th>VISUAL</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physician Leader Forum</strong></td>
<td><img src="image1" alt="Forum Image" /></td>
<td>A 2-day event that provides an in-depth look at JC standards, current patient safety issues, the journey to high reliability and the role of physician leaders in organizational improvement</td>
</tr>
<tr>
<td><strong>Physician Leader Monthly e-newsletter</strong></td>
<td><img src="image2" alt="Newsletter Image" /></td>
<td>Quick news for physician leaders</td>
</tr>
<tr>
<td><strong>TJC Physician Leaders</strong></td>
<td><img src="image3" alt="Leaders Image" /></td>
<td>TJC Physician leaders → White Papers, Videos, Scientific Journals</td>
</tr>
<tr>
<td><strong>JC Physician Blog</strong></td>
<td><img src="image4" alt="Blog Image" /></td>
<td>Leadership Blog</td>
</tr>
<tr>
<td><strong>CMO Academy (Online Course)</strong></td>
<td><img src="image5" alt="Academy Image" /></td>
<td>Online course for Chief Medical Officers</td>
</tr>
</tbody>
</table>

### High Reliability Resources (e.g. ORO 2.0)

- **High reliability organizational assessment and resources**

### Booster Packs

- **Searchable documents intended to provide detailed information about a single standard or topic area**

### Webinars

- **New webinar series highlights Proven Practices from 5 Pioneers in Quality™ Expert Contributors**
  - Check out our new webinar series, "Pioneers in Quality™ Proven Practices." The series launches Aug. 15 at 11 a.m. CT, with a presentation by Virginia Commonwealth University Health System, one of five hospitals and health systems recognized as a 2017 Pioneers in Quality™ Expert Contributor. Read more or register.

### TJC Journal on Quality & Patient Safety

- **A key component in helping healthcare organizations to improve patient safety and quality of care.**

---

© 2018 Joint Commission Resources. All Rights Reserved.
The Importance of SAFETY CULTURE on the Journey to Zero Harm
The Importance of SAFETY CULTURE to Quality and Patient Safety

Definition

- Safety culture is the product of individual and group beliefs, values, attitudes, perceptions, competencies and patterns of behavior that determine the organization’s commitment to quality and patient safety.
The Importance of SAFETY CULTURE to Quality and Patient Safety

Lessons from industry partners – Institute for Safe Medical Practices (ISMP)

<table>
<thead>
<tr>
<th>“At least once in the past year”</th>
<th>2003 N=2095</th>
<th>2013 N=4884</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Assumed order was correct to avoid contact</td>
<td>39</td>
<td>33</td>
</tr>
<tr>
<td>2. Asked a colleague to talk to prescriber</td>
<td>39</td>
<td>38</td>
</tr>
<tr>
<td>3. Pressured to act, despite safety concern</td>
<td>49</td>
<td>39</td>
</tr>
<tr>
<td>4. Assumed safe order due to reputation</td>
<td>34</td>
<td>30</td>
</tr>
<tr>
<td>5. Past disrespectful behavior altered handling of order clarification or question (% answered YES)</td>
<td>49</td>
<td>44</td>
</tr>
<tr>
<td>6. My organization deals effectively with disrespectful behavior (% answered YES)</td>
<td>61</td>
<td>56</td>
</tr>
</tbody>
</table>

Source: ISMP
2003 Intimidation: Practitioners Speak Up About This Unresolved Problem
2013 Unresolved Disrespectful Behavior in Healthcare - Practitioners Speak Up Again

Twice the # of respondents
The Importance of SAFETY CULTURE to Quality and Patient Safety

Improved Process for Assessing Safety Culture on Survey

Expect to see a deeper dive into safety culture through these survey activities:

– Opening session
– Daily briefing
– Individual and System Tracers
– Leadership Session
The Importance of SAFETY CULTURE to Quality and Patient Safety

Resources for Safety Culture

11 Tenets of a Safety Culture

**Definition of Safety Culture**

Safety culture is the sum of what an organization is and does in the pursuit of safety. The Patient Safety Systems (PSS) chapter of The Joint Commission's accreditation manual defines safety culture as the product of individual and group beliefs, values, attitudes, perceptions, competencies, and patterns of behavior that determine the organization's commitment to quality and patient safety.

1. **Apply a transparent, nonpunitive approach to reporting and learning from adverse events, close calls and near misses.**
2. **Use clear, fast, and transparent risk-based processes for recognizing and distinguishing human errors and system errors from unsafe, blaming error actions.**
3. **CEOs and all leaders adopt and model appropriate behaviors and champion efforts to eradicate or minimize behaviors.**
4. **Policies support safety culture and the reporting of adverse events, close calls and near misses. These policies are connected and communicated to all team members.**
5. **Recognize care team members who report adverse events and close calls, who identify unsafe conditions, or who have good suggestions for safety improvements. Share these “True heroes” with all team members (i.e., feedback loop).**
6. **Determine an organizational baseline measure on safety culture perception using a validated tool.**
7. **Analyze a safety culture survey results from across the organization to find opportunities for quality and safety improvement.**
8. **Use information from safety assessments and/or surveys to develop and implement discipline-specific and organization-wide quality and safety improvement initiatives designed to improve the culture of safety.**
9. **Embed safety culture training into quality improvement projects and organizational processes to strengthen safety systems.**
10. **Periodically assess system strengths and vulnerabilities, and prioritize items for enhancement or improvement.**
11. **Repair organizational assessments of safety culture every 18 to 24 months to review progress and maintain improvements.**
The Importance of SAFETY CULTURE to Quality and Patient Safety

Improved Process for Assessing Safety Culture on Survey: Standards

Assessment –
LD 03.01.01 EP1: Leaders regularly evaluate the culture of safety and quality using valid and reliable tools.

Strengthening Systems –
- LD 03.01.01 EP 2. Leaders prioritize and implement changes identified by the evaluation (of safety culture).
- LD 03.01.01 EP5. Leaders create and implement a process for managing behaviors that undermine a culture of safety.

Trust/Intimidating Behavior –
LD 03.01.01 EP4. Leaders develop a code of conduct that defines acceptable behavior and behaviors that undermine a culture of safety.

Identifying Unsafe Conditions –
LD 04.04.05 EP 3. The scope of the safety program includes the full range of safety issues, from potential or no-harm errors to hazardous conditions and sentinel events.

Accountability/Just Culture -
LD 04.04.05 EP 6: The leaders provide and encourage the use of systems for blame-free internal reporting of a system or process failure, or the results of a proactive risk assessment.
How **PROCESS IMPROVEMENT** Can be Used to Transform Your Vision Into a Sustained Future State
The Importance of PROCESS IMPROVEMENT to Quality and Patient Safety

Update for those who haven’t been surveyed since 2016…

SAFER™ Matrix - Survey Analysis for Evaluating Risk

SAFER™ Matrix - an approach for identifying and communicating risk levels associated with requirements for improvement identified during surveys

- A single graphic that depicts how risk is distributed across your organization
- Where your greatest risk is
- Where you should consider prioritizing improvement

Contact your Account Executive for additional information.
The Importance of PROCESS IMPROVEMENT to Quality and Patient Safety

Hospital SAFER™ Matrix – 6/01/2017 through 5/31/2018 (n=1365)
Average number of Requirements for Improvement = 31.59

Hospital Requirements for Improvement (RFI) Distribution
For Full and Initial Hospital surveys from 06/01/2017 through 05/31/2018 (n=1365)

<table>
<thead>
<tr>
<th>Immediate Threat to Life</th>
<th>0.50%</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>1.33%</td>
</tr>
<tr>
<td>Moderate</td>
<td>16.04%</td>
</tr>
<tr>
<td>Low</td>
<td>43.02%</td>
</tr>
<tr>
<td>Limited</td>
<td>60.39%</td>
</tr>
</tbody>
</table>
The Importance of PROCESS IMPROVEMENT to Quality and Patient Safety

The 411 and Survey Enhancements you will hear more about today

1. Sterile Medication Compounding - in the hospital and at remote ambulatory locations

2. Suicide Prevention – guidance for psychiatric hospitals, hospitals with psychiatric units, general wards & emergency departments

3. High Level Disinfection and Sterilization - in the hospital and at remote ambulatory locations

4. Renal Dialysis – very technical and high risk areas
The Importance of PROCESS IMPROVEMENT to Quality and Patient Safety

The 411 Resources
How process improvement can be used to transform your vision into a sustained future state

<table>
<thead>
<tr>
<th>STERILE MEDICATION COMPOUNDING</th>
<th>Blog post</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>[<a href="https://www.jointcommission.org/at">https://www.jointcommission.org/at</a> home with the joint commission/certification reports of compounding hoods and rooms affecting accreditation decisions/](<a href="https://www.jointcommission.org/at">https://www.jointcommission.org/at</a> home with the joint commission/certification reports of compounding hoods and rooms affecting accreditation decisions/)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SUICIDE PREVENTION</th>
<th>Perspectives</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><a href="https://jointcommission.sharepoint.com/ier/Perspectives/2017/November%202017.pdf">https://jointcommission.sharepoint.com/ier/Perspectives/2017/November%202017.pdf</a></td>
</tr>
<tr>
<td></td>
<td><a href="https://jointcommission.sharepoint.com/ier/Perspectives/2018/January%202018.pdf">https://jointcommission.sharepoint.com/ier/Perspectives/2018/January%202018.pdf</a></td>
</tr>
<tr>
<td></td>
<td><a href="https://jointcommission.sharepoint.com/ier/Perspectives/2018/February%202018.pdf">https://jointcommission.sharepoint.com/ier/Perspectives/2018/February%202018.pdf</a></td>
</tr>
<tr>
<td></td>
<td><a href="https://jointcommission.sharepoint.com/ier/Perspectives/2018/March%202018.pdf">https://jointcommission.sharepoint.com/ier/Perspectives/2018/March%202018.pdf</a></td>
</tr>
<tr>
<td></td>
<td>Sentinel Event Alert</td>
</tr>
<tr>
<td></td>
<td><a href="https://www.jointcommission.org/sea_issue_46/">https://www.jointcommission.org/sea_issue_46/</a></td>
</tr>
<tr>
<td></td>
<td>Standards FAQ</td>
</tr>
<tr>
<td></td>
<td>Suicide panel</td>
</tr>
<tr>
<td></td>
<td><a href="https://www.jointcommission.org/panel_issues_suicide_prevention_recommendations/">https://www.jointcommission.org/panel_issues_suicide_prevention_recommendations/</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HIGH-LEVEL DISINFECTION AND STERILIZATION</th>
<th>HAI portal</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><a href="https://www.jointcommission.org/topics/hai_portal_disinfection_sterilization.aspx">https://www.jointcommission.org/topics/hai_portal_disinfection_sterilization.aspx</a></td>
</tr>
<tr>
<td></td>
<td>Quick Safety</td>
</tr>
<tr>
<td></td>
<td>[<a href="https://www.jointcommission.org/issues/article.aspx?ArticleId=1tq5fW0O4yFSp4CtvZNCloOExn2G048U71Qou6">https://www.jointcommission.org/issues/article.aspx?ArticleId=1tq5fW0O4yFSp4CtvZNCloOExn2G048U71Qou6</a> 7b%2bIQ%2bQg](<a href="https://www.jointcommission.org/issues/article.aspx?ArticleId=1tq5fW0O4yFSp4CtvZNCloOExn2G048U71Qou6">https://www.jointcommission.org/issues/article.aspx?ArticleId=1tq5fW0O4yFSp4CtvZNCloOExn2G048U71Qou6</a> 7b%2bIQ%2bQg)</td>
</tr>
<tr>
<td></td>
<td>The Source</td>
</tr>
</tbody>
</table>
The Importance of PROCESS IMPROVEMENT to Quality and Patient Safety

Other improvements in leading the way to zero

- Evidence of Standards Compliance (ESC) Redesign
- Improved Accreditation Report
- Standards Interpretation On Site Support
- Intracycle Monitoring – More focus on high risk trends and improvement across the accreditation cycle
- Consistency of Standards Interpretation
- CMS Validation Survey
- Power of Data access
- Preventive Analysis
For The Joint Commission it is about…..

Vision, Mission and a New Culture

**Vision**
*All people always experience the safest, highest quality, best-value health care across settings.*

**Mission**
*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.*
Thank You!