



Sustaining the Improvement We Need

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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 demanding excellence



Key Improvements

Core measures in use since 2002 have improved markedly; several to extremely high levels of excellence

Acute MI: 2007 Hospital Performance

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



How Is Health Care Doing?

- ▶ We have made some progress

- ⇒ Improvement on most public measures

- ⇒ Level of attention has never been higher


- ▶ Evidence of improvement is poor

- ⇒ Data are old, sparse, and incomplete

- ⇒ Most apply to hospitals, fewer for ambulatory care; almost none for home health, ambulatory surgery, long-term care

The Changing Quality Landscape

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



The Public-Private Partnership Overseeing Quality in Health Care

- ▶ Government has played a limited role in quality oversight up to the present
- ▶ Two related forces threaten this relationship
 - 1) Bad things still happen in good hospitals
 - ➔ At Joint Commission accredited hospitals
 - 2) Routine safety processes break down
- ▶ Public stakeholders are losing patience

BREAKING NEWS: JPMorgan Chase raises Bear Stearns offer to \$10 per

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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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Wednesday, May 7, 2008

State faults St. Joseph team for surgery on wrong knee

Even after patient noted error, team operated on right instead of left at Orange hospital.

BY COURTNEY PERKES

The Orange County Register

Comments 30 | Recommend 7

A surgical team at St. Joseph Hospital in Orange made repeated errors that led to a patient operation on the wrong knee, according to a state investigation made public today.

Even after the unidentified patient noted what knee needed surgery, the surgical team still performed the operation on the wrong side, the report says. St. Joseph could be fined up to \$25,000 by the California Department of Public Health for the



CHECK LIST: More hospitals, including St. Joseph in Orange, are borrowing safety protocol from the airline industry to prevent surgical errors. Here a surgeon at Kaiser Permanente's Anaheim Medical Center in 2006 checks X-rays as part of its pre-surgical safety program. St. Joseph could be fined up to \$25,000 by the California Department of Public Health for a surgical error made earlier this year.

FILE PHOTO: THE REGISTER

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Hospital tells of surgery on wrong side

The Boston Globe

By Stephen Smith
Globe Staff / July 4, 2008

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An experienced surgeon at Beth Israel Deaconess Medical Center operated on the wrong side of a patient this week, a serious medical mistake disclosed in an e-mail that hospital administrators sent to staff members yesterday.

State authorities are investigating the errant surgery, which happened Monday during an elective procedure. A hospital administrator declined to provide specifics about the operation but said it did not involve removal of organs and did not cause permanent damage to the middle-aged patient, who was expected to suffer short-term discomfort. A state health regulator described the operation as an orthopedic procedure.

The mistake happened as hospitals, regulators, and insurers are devoting unprecedented attention to combating medical errors. Last month, the state said it would stop reimbursing hospitals for medical costs associated with mistakes.

Figures from the state show that in the first five months of the year, hospitals statewide reported five wrong-sided surgeries. On average, about 15 such errors are reported annually, said Paul Dreyer, director of the state's Bureau of Health Care Safety and Quality.

Wrong-Side Surgery At Gardner's Heywood Hospital

GARDNER (AP) — Heywood Hospital in Gardner is reviewing policies and procedures after a surgeon operated on the wrong knee of a patient who needed arthroscopic surgery.

Hospital officials say they are investigating factors that may have contributed to the error.

Hospital President and CEO Daniel Moen apologized in a statement and said the hospital is committed to making sure it doesn't happen again.

Neither the name of the orthopedic surgeon nor the patient were released.

The hospital acknowledged responsibility for the error and did not bill the patient, who is not expected to experience any long-term problems.

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- [R.I. Hospital Fined For 3rd Brain Surgery Mistake \(11/27/2007\)](#)
- [Boston Surgeon Operated On Wrong Side Of Patient \(7/4/2008\)](#)
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WBZ's Most Popular

 **Health**



Rhode Island news

Surgeon operates on wrong knee at Miriam Hospital

01:00 AM EDT on Saturday, September 20, 2008

By Felice J. Freyer

Journal Medical Writer

A doctor at the Miriam Hospital yesterday operated on the wrong knee of a patient undergoing elective surgery, despite the hospital's increased focus on preventing such wrong-site surgeries.

The surgical team had apparently followed the key safety protocols, including marking the correct knee and pausing to verify the site before operating -- but somehow still made the error, according to Dr. Kathleen C. Hittner, hospital president and chief executive officer.

The mistake was first noticed by the patient when she regained consciousness. The hospital then performed the surgery on the correct knee, and the patient is doing well, Hittner said. The patient was scheduled to go home yesterday.



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.

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.

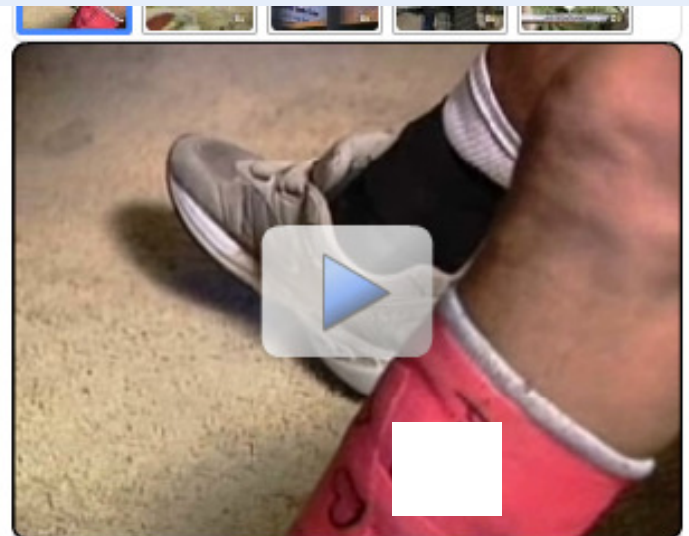
Yet still, the surgeon somehow, cut into and irreversibly locked together the bones in his healthy left ankle.

"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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What Happens When Public Stakeholders Get Impatient?

- ▶ They make laws
 - Legislatures and MRSA
 - NY and office-based surgery
 - Florida and loss of protection for peer review
- ▶ 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
- ▶ Can be very appealing to physicians, nurses, pharmacists 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 particular culture and a set of operating and management principles and tools
- ▶ 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

Robust Process Improvement

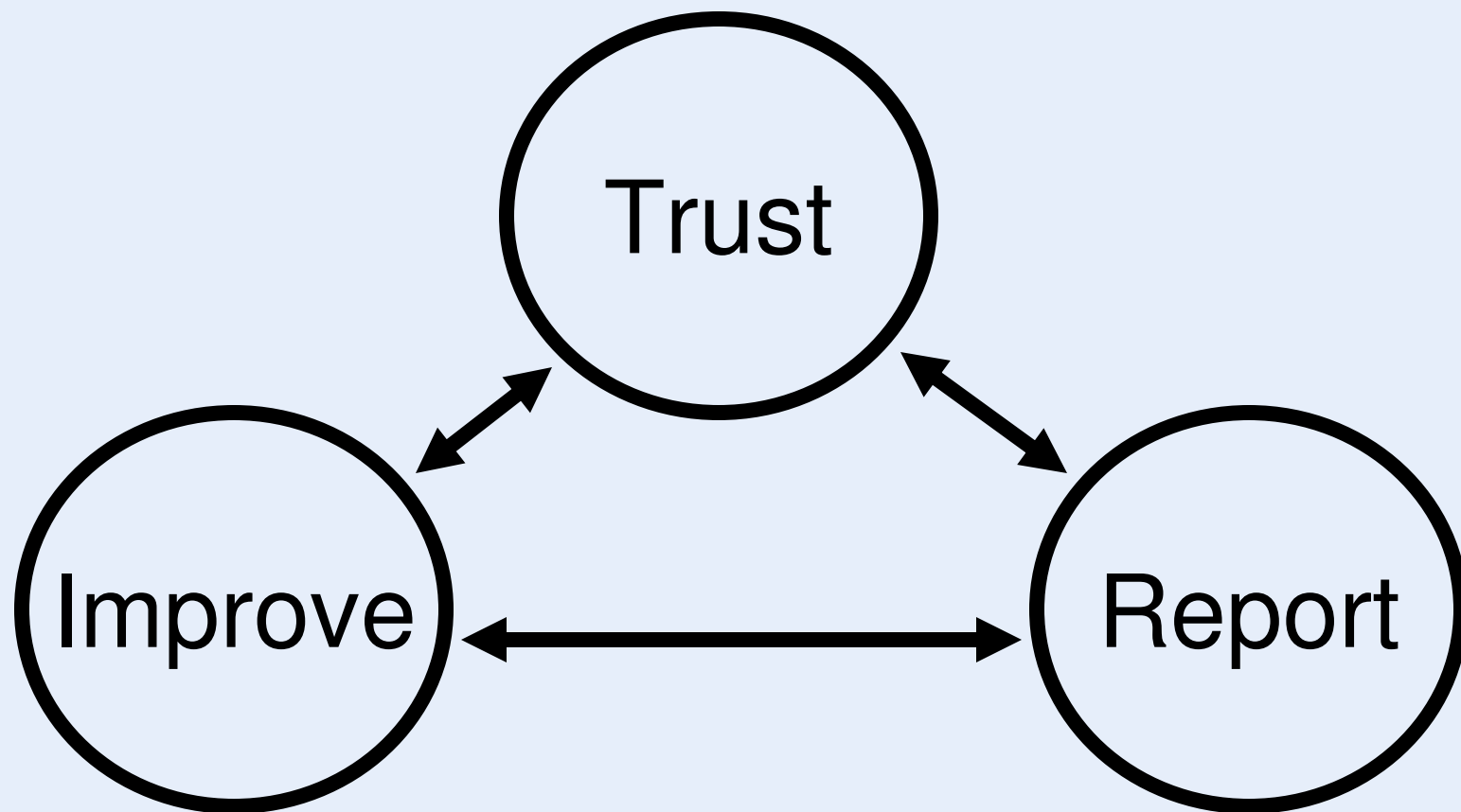
- ▶ Essential to producing durable health care excellence consistently
- ▶ Capacity for such process improvement in the delivery system is limited
- ▶ The Joint Commission is adopting these tools for internal improvement
- ▶ The Joint Commission will lead an effort to facilitate more rapid and widespread development and adoption of generalizable, proven solutions



The Joint Commission is Changing

- ▶ With our adoption of lean, six sigma, and change acceleration, we are rapidly changing our culture:
 - Focus on customer service
 - Simplify our processes
 - Reduce our costs
- ▶ Projects now underway in all these areas (e.g., inconsistent interpretations)

The 3 Imperatives of a Safety Culture



Imperative #1: Trust

- ▶ Aim is not a “blame-free” culture
- ▶ Safety culture incorporates clear and enforced discipline for some acts
 - ⇒ Often called “culpable” acts
 - ⇒ 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' link at the top, followed by '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' in white. Below this header, the text reads 'Issue 40, July 9, 2008' followed by the title 'Behaviors that undermine a culture of safety' in bold. The main body of text discusses the impact of intimidating and disruptive behaviors on patient care and safety.

The Joint Commission

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Sentinel Event Alert

Issue 40, July 9, 2008

Behaviors that undermine a culture of safety

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.

ISMP Workplace Intimidation Survey

Results from ISMP Survey on Workplace Intimidation

[Click here to view article "Intimidation: Practitioners speak up about this unresolved problem \(Part I\)"](#)
[Click here to view article "Intimidation: Mapping a plan for cultural change in healthcare \(Part II\)"](#)

Total: 2095

(1) Please tell us how frequently in the past year you've encountered potentially intimidating behaviors.

Key: Often = more than 10 times this year; Sometimes = 3-10 times this year; Rarely = 1-2 times this year; Never = no occurrences.

Potentially Intimidating Behaviors	By Physicians/Prescribers				By Others (e.g., pharmacist, nurse, supervisor)			
	Often	Sometimes	Rarely	Never	Often	Sometimes	Rarely	Never
a. Reluctance or refusal to answer your questions, return phone calls or pages	20%	40%	28%	13%	8%	22%	41%	29%
b. Condescending language or voice intonation	28%	39%	25%	7%	14%	32%	36%	18%
c. Impatience with questions	25%	41%	26%	7%	12%	32%	38%	19%
d. Strong verbal abuse	6%	16%	34%	44%	3%	10%	26%	60%
e. Negative or threatening body language	5%	15%	29%	51%	4%	10%	23%	63%
f. Reporting you to your manager (actual or threat)	4%	11%	27%	59%	3%	10%	24%	63%
g. "Just give what I/the attending ordered."	12%	25%	33%	31%	3%	10%	21%	66%
h. Physical abuse	0%	0%	4%	95%	0%	1%	2%	97%

ISMP, 2003---Respondents: Nurses 74%, pharmacists 17%

Near Misses = “Free Lessons”

- ▶ Critical barometer of safety culture
- ▶ Punitive organizational culture
 - ⇒ never finds out
- ▶ Bureaucratic culture
 - ⇒ celebrates
- ▶ High reliability organization
 - ⇒ reacts as if it were an adverse event

Traditional Approach to Adverse Events Needs Improvement


- ▶ Twin problems
 - Current tools often not used well
 - Need new tools
- ▶ Nomenclature is misleading
- ▶ “Root cause analysis” often superficial
- ▶ No systematic way to compile learning across events and over time



The Joint Commission's Role

- ▶ The Joint Commission invented sentinel events and brought RCA to health care
- ▶ Uniquely positioned to create the next generation of knowledge and tools to guide more effective investigation and analysis of adverse events
- ▶ Investing now to produce these tools

Recent Joint Commission Initiatives

- 
- ▶ Major improvements to standards and survey process in past 5 years
 - ▶ Changes focus accreditation much more sharply on safety and quality
 - 1) Core measure program
 - 2) National patient safety goals
 - 3) Tracer methodology for surveys
 - 4) Unannounced visits



The Present Joint Commission

- ▶ Continue to aggressively improve standards and survey process (for example, the Standards Improvement Initiative)
- ▶ Increase confidence that improving on measures and complying with standards will improve health outcomes
- ▶ Use robust process improvement to create and deliver effective solutions to you

Hospital Patient Safety: Characteristics of Best-Performing Hospitals

JOURNAL OF HEALTHCARE MANAGEMENT 52:3 MAY/JUNE 2007

Daniel R. Longo, Sc.D., professor, Department of Family Medicine, Virginia Commonwealth University School of Medicine, Richmond; John E. Hewett, Ph.D., professor

We found that, for both univariate and multivariate analyses, Joint Commission accreditation was uniformly, strongly, and consistently associated with more extensive implementation of patient safety systems, both at specific points in time and with respect to change over time. Accreditation status was the only organizational characteristic that consistently emerged in identifying which hospitals have more extensively implemented patient safety systems. Using the summary measure, we found that accredited hospitals had statistically significant improvement ($p = .01$), while nonaccredited hospitals did not ($p = .21$).

The Next Generation Joint Commission

- ▶ We are the world leader in setting standards for health care quality and judging organizations' performance against those standards
- ▶ We are becoming as superlative in learning and improvement as we are in standards, measurement, and accreditation
- ▶ Next generation of standards will assess institutions' capacity for improvement



The Big Challenge

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