ZERO Patient Harm - Is That Achievable in Our Hospitals?

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A. Introduction

It may seem a strange question to ask and a far-fetched dream to have healthcare services with NO harm whatsoever. Imagine a hospital day passing with zero harm, what does that mean? It means zero patient falls, zero complications of care, zero healthcare-associated infections, zero medication errors, and zero patient safety events of any kind. Zero harm also includes no harm to employees and visitors. For the first moment, achieving zero harm may sound impossible to achieve because we were brought up with lower expectation. This is especially true in a hospital setting with high complexity of services where multidisciplinary groups of professionals interact together to produce an intangible service.

Looking back in the history of medical care we find an old concern to prevent harm while providing patient care. It is believed that the Hippocratic Oath (460-370 BC) included the phrase "First do no harm" (Latin: Primum non nocere) although the words do not appear in the original version of the oath. This phrase came up again in anecdotes documented by leading medical figures dating back to the 17th Century. Also, Florence Nightingale's notes on hospitals in 1859 highlighted that hospitals should do the sick no harm. (1)

The striking report published by the Institute of Medicine (IOM) in the year 2000 named "To Err is Human" was considered a wake-up call. It suddenly magnified the problem of hospital-associated adverse events to the extent that makes it difficult to believe that we can reach to Zero harm.

After the IOM's report, many initiatives started to deal with the problem of patient harm in hospitals. Many initiatives were launched such as the 100,000 lives campaign. Most recently, healthcare practitioners, scholars and accrediting bodies are advocating the importance to establish and nourish an effective safety culture within the hospitals to reduce, or prevent, patient harm.

B. Leadership Commitment

Providing effective care while protecting the safety of patients should be the first priority of hospital leadership. Competent leaders can contribute to improvements in safety by implementing the eleven tenets of safety culture that was distributed by The Joint Commission in March 2017 as a roadmap to reduce or eliminate adverse events in hospitals: (2)

1. Apply a transparent, non-punitive approach to reporting and learning from adverse events and near-misses
2. Use clear, just, and transparent risk-based processes for recognizing system errors
3. Adopt and model appropriate behaviors
4. Implement policies to support reporting of adverse events and close calls
5. Recognize care team members who report adverse events and close calls, who identify unsafe conditions, or who have good suggestions for safety improvements
6. Determine an organizational baseline measure on safety culture
7. Analyze safety culture survey results
8. Use information from safety assessments to implement quality and safety improvement initiatives
9. Embed safety culture team training into quality improvement projects
10. Proactively assess system strengths and vulnerabilities, and prioritize them for enhancement or improvement
11. Repeat organizational assessment of safety culture every 18 to 24 months to review progress and sustain improvement

Hospital and healthcare leaders should identify, and deal with, intimidating and disruptive behaviors in their day-to-day operations. Behaviors that undermine a culture of safety continue to be a problem in health care.

C. Culture of Safety

The Joint Commission defines the safety culture as "the sum of what an organization is and does in the pursuit of safety. It 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." Culture of safety is considered as a collaborative environment in which skilled clinicians treat each other with respect, leaders drive effective teamwork and teams learn from errors and near misses. (3)

James Reason describes the main elements of a safety culture as:

- Just culture – people are encouraged, even rewarded, for providing essential safety-related information, but clear lines are drawn between human error and at-risk or reckless behaviors
- Reporting culture – people report their errors and near-misses
- Learning culture – the willingness and the competence to draw the right conclusions from safety information systems, and the will to implement major reforms when their need is indicated. (4)

The Institute of Nuclear Power Operations defined safety culture characteristics that are adaptable to the health care environment:

1. Leaders demonstrate commitment to safety in their decisions and behaviors
2. Decisions that support or affect safety are systematic, rigorous and thorough
3. Trust and respect permeate the organization
4. Opportunities to learn about ways to ensure safety are sought out and implemented
5. Issues potentially impacting safety are promptly identified, fully evaluated, and promptly addressed and corrected commensurate with their significance
6. A safety-conscious work environment is maintained where personnel feel free to raise safety concerns without intimidation, harassment, discrimination, or fear of retaliation
7. Planning and controlling work activities so that safety is maintained. (5)

D. Process Improvement Tools and Methods

The robust process improvement (RPI) is a model developed by The Joint Commission and it consists of a combination of Lean Six Sigma and change management tools. The RPI model provides a potent set of tools to provide a systematic approach to solving complex

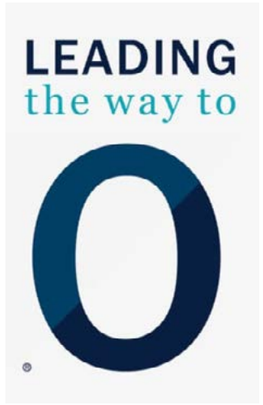
problems in healthcare thus leading to reduced adverse events and improved quality of services.

Mark Chassin MD, a healthcare scholar, along with a group of policy makers are leading a global drive to improve hospital outcomes through the implementation of the High Reliability Organization (HRO) concept. High reliability describes organizations and industries that maintain extraordinarily high levels of quality and safety over long periods of time with no or extremely few adverse or harmful events, despite operating in very hazardous conditions. In healthcare, high reliability means that care is consistently excellent and safe across all services and settings. (6) High reliability helps organizations stay safe through a culture characterized by "collective mindfulness" in which all workers look for, and report, small problems or unsafe conditions before they pose a substantial risk to the organization and when they are easy to fix. Chassin also noted that hospitals usually face what is called "project fatigue" in their drive to nail down the patient harm because so many problems needs attention at the same time. But over the past few years, there were incremental changes in the hospital industry leading to become high reliability organizations with a fully functional culture of safety. (7)

Hospitals usually monitor adverse events and errors by selecting specific key performance indicators (KPIs) such as rate of patient harm as a result of fall per 1,000 patient care days or rate of central line blood stream infection (CLABSI) per 1,000 central-line days, etc. In addition to monitoring and reporting adverse event rates, many hospitals report the time lapse since the last adverse event (in days, weeks or months). For example, 231 days since the last case of ventilator associated pneumonia, central line infection, or patient harm as a result of fall. There are many advantages for this monitoring and reporting methodology. It portrays the positive side of achieving the goal of no patient harm and motivates hospital staff to do their best to prolong the duration of no harm. Reports like that will also send a message of trust among the patients and families utilizing the services of these hospitals. For this reason, many hospitals around the world take pride of publishing their key performance indicators on their own websites.

E. Leading the Way to Zero

The Joint Commission Center for Transforming



Healthcare started a global drive titled Leading the Way to Zero™'. This drive is much larger than just a one-time campaign and is designed to continue making every effort to reach a time when zero harm is the natural byproduct of how patient care is delivered every day.

There is no doubt that hospitals and health care organizations want to provide safer care and patients and their families definitely want to receive healthcare services that are free of harm. It is a challenging goal but not impossible to achieve. Just imagine how a day of zero patient harm in a hospital looks and feels like. This thought by itself is motivating and worth spending every effort to make it come true. This is the right time for all hospitals in our region to adopt and implement policies and practices leading to zero patient harm where safe care is the natural outcome of all what we do.

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