LEADING the way to O™

Did you know?

The Joint Commission Enterprise envisions a future of zero harm and is committed to helping make it a reality.

We believe zero harm is achievable and we're *leading the way to O™* by helping organizations transform the way they work to prevent harm. The Joint Commission Enterprise provides tools and resources to help organizations on their journey to zero harm. Together, we can make health care harm a thing of the past.

If not now, when? If not us, who?

The Joint Commission

ZERO HARM IS POSSIBLE

– **Zero harm means** zero complications of care, zero falls, zero infections, zero missed opportunities for providing effective care, zero overuse and even zero lost revenue. In other words, zero harm of any kind.

– **Humans do make mistakes,** but zero harm does not mean zero mistakes. It means organizations develop systems and processes that reduce the likelihood of a mistake occurring. Highly reliable organizations have safety procedures that stop errors and prevent them from propagating and leading to harm. They also identify problems and unsafe conditions and correct them before they cause harm.

– **We believe zero harm is achievable.** Look at the commercial aviation and nuclear power industries, which employ and sustain high levels of safety despite significant potential for serious harm. This is known as high reliability, which is what we strive for in health care. Getting to zero harm is a journey and takes extraordinary commitment. It doesn't happen overnight, but it is possible.

THE JOINT COMMISSION ENTERPRISE IS LEADING THE WAY TO ZERO HARM

– *Leading the way to Zero™* is the Joint Commission Enterprise's commitment to helping organizations transform the way they work to prevent harm. We do this by working with health care providers and organizations to identify and correct problems *before* they cause harm. Zero harm needs to be the natural result of how patient care is delivered every day.

The Joint Commission Enterprise is leading this initiative because we've seen a multitude of ways that health care can succeed or fail. We have a long history as a champion of quality and safety, and a catalyst for improvement. In the past decade, we have gone beyond our traditional products of accreditation, certification and accreditation-related services to include high reliability products, services and thought leadership. Our surveyors, reviewers, trainers and experts are in health care organizations every day. The unique set of expertise, capabilities and services we've developed qualify us as the only organization with the ability to address this challenge.

– **Leading the way to O is a critical need** because medical errors that cause patient harm have always occurred, but significant attention was not brought to these events until the Institute of Medicine's 1999 report To Err is Human[1] reported that as many as 98,000 Americans may die every year due to preventable medical errors. More recent research suggests the number may be even higher. Health care entities have worked hard to make progress in improving patient care. But it's been slow and incremental. Even today there are 45 incidents each week in which surgery or an invasive procedure is performed on the wrong patient or body part or the wrong surgery is performed altogether. Clearly, we need to make more substantial and systemic changes.

– **Joint Commission Enterprise initiatives improve care.** For example:
  • The *Targeted Solutions Tool® (TST®)* has been shown to lead to significant improvements in hand hygiene, preventing falls, safe surgery and hand-off communications.
  • One health system we worked with achieved zero incidence of ventilator-associated pneumonia, 100 percent compliance with evidence-based quality measures and zero incidence of many other types of patient harm in many of its component hospitals.
  • Other benefits organizations have reported include: reduced readmissions, reduction in catheter infection rates, movement from bottom quartile to top 20 percent in value-based purchasing, additional Medicare reimbursement, reduction in serious safety events, reduction in defective handoffs and ER wait times, increase in time-to-treatment for stroke and reduced hospital stays.

– **We help improve care through accountability.** After the survey process is complete, we require organizations to make improvements to issues that we have identified as well as encourage them to report incidents to us so that we can help them to continue to improve.

– **We can help improve reimbursement.** Certain payors provide bonus points for accreditation and certification that includes things such as implementing antimicrobial stewardship programs, or certification in integrated care or hospital-based palliative care. Further, accredited organizations perform better on quality, safety and performance measures, which leads to improved reimbursement. We also know that accredited nursing homes have half the rate of payment denials as those that aren't accredited.

THE JOINT COMMISSION ENTERPRISE PROVIDES TOOLS AND RESOURCES TO HELP ORGANIZATIONS GET TO ZERO HARM

– **To help health care organizations work towards zero harm,** the Joint Commission Enterprise:
  • Equips health organizations with high reliability tools, approaches and resources to help improve patient care
  • Shares leading practices and collaborates with industry partners
  • Leverages its knowledge and expertise to move quality and patient safety beyond accreditation
  • Evolves the survey process to continually make improvements to patient issues such as ligature risk and pain management
  • Addresses the topic of safety culture during the survey process
  • Created the Center for Transforming Healthcare use RPI to solve health care's most critical safety and quality challenges by continually researching high reliability methodologies and developing tools and resources to achieve this goal

– **Resources provided by the Joint Commission Enterprise** include accreditation and certification across the continuum of care, as well as software solutions, education events, publications, training and advisory services. Some of our offerings include:
  • The Center for Transforming Healthcare's *Targeted Solutions Tools*® for hand hygiene, fall prevention, safe surgery and hand-off communications are provided at no additional cost to domestic and international organizations accredited by The Joint Commission.
  • *ORO*® 2.0, which helps health care organizations assess their readiness for and success with transformation, is free to domestic accredited hospitals.
  Other resources available to health care organizations include:
  • Leading Practice Library of solutions and leading practices culled from thousands of global customers providing all types of care
  • Take Five podcasts on patient safety topics
  • Videos that delve into high reliability and what it looks like
  • Sentinel Event Alerts regarding ongoing issues being reported
  • Patient Safety Systems manual chapter provides guidance on safety-specific standards
  • Webinars on various topics
  • Training and facilitation to help organizations create high-quality *Robust Process Improvement*® *(RPI*®*)* programs, which are customized for each health organization
  • *Leaders Facilitating Change*™ workshop that helps leaders understand and pursue the full leadership engagement necessary to transform an organization

EVERYONE NEEDS TO COMMIT TO ZERO HARM

– *Everyone* **working in the health care industry** – no matter the position – needs to be accountable for safety and quality. When you see something, say something. Repeat the mantra: no harm is OK.

– **Health care organizations can work towards achieving highly reliable health care** by taking these steps:

  • Leadership must be committed to the goal of zero harm.
  • Develop and adopt a safety culture. That means ensuring employees are comfortable reporting errors without fear of retaliation.
  • Incorporate highly effective process improvement tools and methodologies (RPI) into your work.
  • Demonstrate how everyone is accountable for safety and quality.

References
1. Kohn L T, Corrigan J M, Donaldson MS, Institute of Medicine (U.S.) Committee on Quality of Health Care in America. To err is human: building a safer health system. Washington, DC: National Academies Press, 2000.