

Florida Quality News

A publication of the Florida Association for Healthcare Quality -
Healthcare professionals united in advancing Florida's healthcare quality

*Editor's Note: It is with great pleasure that we introduce this segment on **Accrediting Bodies**. We are honored that so many key players in the field of healthcare accreditation were able to accept our invitation to share with us information on their organization, their philosophy or specific initiatives they want to showcase. In this special reprint, we are pleased to present the contribution by The Joint Commission Center for Transforming Healthcare.*

Helping Health Care Organizations Help Patients Joint Commission Teams Up to Take Aim at Safety Lapses

**Anne Marie Benedicto, Chief of Staff, Executive Vice President of Support Operations
The Joint Commission**

The statistics are widely known throughout the health care industry—health care-associated infections kill nearly 100,000 Americans each year and cost U.S. hospitals \$4 billion to \$29 billion annually to combat. What has eluded us is a solution.



Recognizing that there is no quick fix, The Joint Commission has teamed up with hospitals and health systems across the country to address hand hygiene failures as a critical patient safety problem—one that requires strategies far more complex than just putting up signs urging caregivers to wash their hands. The hand hygiene project is the first for the Joint Commission Center for Transforming Healthcare. The hand hygiene project, along with all other Center projects, uses Robust Process Improvement™ (RPI) methods, a fact-based, systematic, and data-driven problem-solving methodology that incorporates tools and methods from Lean Six Sigma and change management. Using RPI, organizations seek to create and sustain a culture of safety by measuring the magnitude of a specific safety problem, pinpointing the contributing causes, developing specific solutions that are targeted to each cause, thoroughly testing the solutions, and adopting successful targeted solutions to improve organization performance. These proven and practical strategies, long used by other industries, aim to help transform American health care into a high-reliability industry that ensures patients receive the safest, highest quality care they expect and deserve.

For example, the front-line work of the hospitals participating in the Center's hand hygiene project shows that the random observation long relied upon by many health care organizations to measure hand-hygiene compliance is not enough. In fact, the hospitals found on average that caregivers washed their hands less than 50 percent of the time. Why? And how could those unacceptable rates be changed?

Examples of the causes found and solutions tested by the hand hygiene project are listed below. A comprehensive list of contributing factors to hand hygiene failures, and the solution sets that have been proven to be effective against these factors can be found on our Web site:

Cause: Safety culture does not stress hand hygiene at all levels.

Solutions: Make hand washing a habit; commitment of leadership to achieve targeted compliance goals; leaders serve as role models; hold everyone—doctors, nurses, therapists, food service, housekeeping staff—accountable; tailor education in proper hand hygiene for specific disciplines; communicate frequently; and use real time performance feedback.

Cause: Ineffective placement of dispensers or sinks.

Solutions: Provide easy access to hand hygiene equipment and alcohol-based hand rub dispensers.

Cause: Hands full.

Solutions: Create a place for everything—for example, a health care worker with full hands needs a dedicated space where he or she can place items while washing hands.

Limit entries and exits from a patient's room – make supplies available in room and eliminate causes that require staff to leave room.

Although the causes (e.g., eliminating distractions that cause caregivers to leave a patient or tailoring education) may appear to be self-evident, these are exactly the types of changes in practices that are crucial to identify and address in order to improve safety. Health care must move away from a reliance on individual performance and build safety into its systems.

Hand washing is only the Center's first patient safety challenge. Other projects underway include prevention of wrong site surgery, including wrong procedure and wrong person surgeries, and eliminating breakdowns in hand-off communications (a hand-off is a transfer and acceptance of patient care responsibilities achieved through effective communication). Future projects will improve other aspects of infection control such as eliminating surgical site infections, mix-ups in patient identification, and medication errors.

Addressing the capacity of organizations to create a culture of safety is the only way that health care can keep up with an ever changing, moving target of quality and safety. Creating and sustaining improvement is difficult. It requires continuous attention, monitoring, feedback of the processes put into place, and automation where possible.

But to make health care more effective, more efficient, and less vulnerable to failure, we must take a new approach that transforms health care. Ultimately, this comprehensive approach is what will transform health care from an industry in which human errors that cause patient harm, such as failure to perform hand hygiene, are no longer the norm. These are the solutions that will help health care professionals to achieve the magnitude and breadth of improvement that is sought by health care organizations, by patients and their families, by physicians and other clinicians, and by other public and private stakeholders.

Though the hospitals that are working with the Center are using RPI tools to develop targeted solutions, hospitals are not required to utilize Lean and Six Sigma concepts in order to implement the solutions.

For more information about the Joint Commission Center for Transforming Healthcare, please visit <http://www.centerfortransforminghealthcare.org/> or contact The Joint Commission Center for Transforming Healthcare, at cth@jointcommission.org.

SAVE THE DATE!!

The **FAHQ Annual Conference** has been scheduled for **April 12-15, 2011** in Orlando, FL at the Sonesta Hotel. Titled ***The Mystery of Mastery: How We are Making Health Care Better!*** the conference will focus on Best Practices in Healthcare Quality. Watch for the **Call for Participants**, coming later this month. To be added to our mailing list to receive the Call for Participants, click [here](#)

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