Imagine a day of zero harm. What would that look and feel like at your healthcare organization? Zero patient falls, zero complications of care, zero healthcare-associated infections and zero patient safety events of any kind. Zero harm also means zero harm to employees and visitors, and zero lost opportunities to provide exemplary care.

It’s clear that if we want substantially better results in healthcare, we need a different approach to improvement. High reliability is that different approach. I often hear from leadership and staff that “zero harm is impossible to achieve.” The goal of zero harm is a daunting challenge for healthcare executives—and for physicians, nurses, managers and boards. But we are beginning to see it from some of our accredited organizations.

Memorial Hermann Health System, Houston, collaborated with the Joint Commission Center for Transforming Healthcare on the center’s hand hygiene project. The results were dramatic, as the average compliance across all of MHHS’ hospitals improved from 58 to 96 percent. In addition, one hospital received the system’s Certified Zero Award for having no central line-associated blood stream infections for 12 months. And, five hospitals had no cases of ventilator-associated pneumonia during that same year.

Cincinnati Children’s Hospital Medical Center also has made significant improvements. The hospital reduced serious patient safety events by 80 percent and lost time days by 83 percent. And, it continues to drive down injury and illness rates among employees. These results were achieved by a high degree of board engagement and a number of organizationwide safety initiatives, including the incorporation of safety huddles into the hospital’s daily observation briefs.

Zero harm is possible—it is an achievable goal. Leading the Way to Zero

MHHS and Cincinnati Children’s Hospital Medical Center are just two examples of healthcare organizations leading the way to zero harm. Together, we can identify and address the quality and safety problems that continue to harm patients despite our best efforts to stop them.

It’s clear that if we want substantially better results in healthcare, we need a different approach to improvement. High reliability is that different approach. It is not a one-time project. It is not a buzzword. It is about transforming organizations so that zero harm is the natural byproduct of the way we care for patients every day.

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.

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, according to the book Managing the Unexpected: Resilient Performance in an Age of Uncertainty, Second Edition (Jossey-Bass, 2007), authored by Karl E. Weick and Kathleen M. Sutcliffe.
In a 2013 *Millbank Quarterly* article, the late Jerod M. Loeb, PhD, and I detailed a framework for high reliability in healthcare called the “high-reliability healthcare maturity model.” The model consists of three foundational domains that are mutually reinforcing:

1. A leadership commitment to zero harm
2. Establishment of a safety culture in which all employees speak up to prevent harm
3. Deployment of highly effective process improvement methods

**If Not Now, Then When? Get Started Today**

As the model outlines, leadership commitment is the first and most essential step in the journey to high reliability. It requires that leaders commit to the ultimate goal of zero patient harm. As a healthcare executive, no matter where your organization is on its high-reliability journey, you can get started or progress further today. So, where can you begin?

If your organization isn’t already doing so, I strongly encourage the adoption of robust process improvement—a combination of Lean Six Sigma and change management. RPI provides a potent set of tools to provide a systematic approach to solving complex problems.

For its part, the Joint Commission Center for Transforming Healthcare also has several resources available to help organizations achieve zero harm. These tools are especially useful for healthcare executives in identifying and addressing safety and quality problems specific to their own organization:

- Oro 2.0 is an online organizational assessment with resources designed to guide hospital leadership on the road to high reliability. Senior leaders take the assessment individually and then come together as a group to take the assessment again, with the goal of reaching consensus on their organization’s strengths and weaknesses.
• Targeted Solutions Tool is an online application that takes organizations through a step-by-step process to accurately measure actual performance, identify barriers to excellent performance and employ proven solutions for some of the most persistent quality and safety problems. Solutions are customized to address each organization’s specific barriers.

The center’s resources and tools are free to Joint Commission-accredited organizations. For more information, visit centerfortransforminghealthcare.org.

Today, healthcare is more diverse, more multidisciplinary and more connected than ever before. It is imperative that organizations keep pace. This is where The Joint Commission can help—by going beyond accreditation to work with organizations on Leading the Way to Zero. No patients hurt by care, coupled with improved processes, sustained excellence, financial savings, engaged team members and, most importantly, safer and more effective patient care—that’s what a day of zero harm looks and feels like.

To learn more about high reliability, I encourage you to join me and my colleagues M. Michael Shabot, MD, executive vice president/system chief clinical officer, Memorial Hermann Health System, and Gary R. Yates, MD, partner, Strategic Consulting, Press Ganey, at ACHE’s High-Reliability Healthcare Boot Camp during the 2018 Congress on Healthcare Leadership on March 25. Visit ache.org/Congress/Bootcamps.cfm to learn more.
And, to stay up to date with The Joint Commission, please visit us at jointcommission.org. ▲

Mark R. Chassin, MD, FACP, is president and CEO, The Joint Commission, Oakbrook Terrace, Ill. (mchassin@jointcommission.org).