Zero Harm Is the Goal

By Erin S. DuPree, MD, FACOG

Ask 10 healthcare leaders if they’ve heard of high reliability, and it’s almost certain all 10 will say they have. Ask those same 10 to define high reliability, and things get interesting.

Many healthcare leaders have a genuine interest in high reliability but often do not know exactly what it means or how to incorporate it among their organization’s other priorities. They just know it sounds right to say their organization is working to “get to high reliability,” and they hope it will be the silver bullet that solves all problems. Unfortunately, the term “high reliability” can become a buzzword when used without understanding what it is. Employed this way, it may sound great but lack substance—all sizzle and no steak.

The first truly high-reliability organizations (HRO) acknowledge is how much they don’t know and how much there is to learn. A culture of learning and teaching is at the core of an HRO. Other complex, high-risk enterprises—such as the airline and nuclear power industries, as well as amusement parks—have adopted this concept and avoided catastrophic events for long periods of time.

In an HRO, everyone from the front lines to the boardroom takes responsibility for safety, which first and foremost requires trust. In a trusting organization, management and staff recognize that everyone across the organization has expertise and contributes to patient care. Peers hold each other accountable. Staff members feel comfortable reporting errors and variations in care to their supervisors. Everyone feels accountable for safety, which is really a relentless focus on improvement, and behaves accordingly.

In fact, these organizations prize the identification of errors and close calls for the lessons that can be extracted from them. Through careful analysis of what occurred before the error or near miss took place, a specific weakness in safety protocols or procedures is highlighted and can be remedied to reduce the risk of future failures. There is a focus on prevention, not reaction. The further upstream the problem is, the more important it is to fix.

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High-reliability organizations

Few healthcare organizations today have set zero harm as an explicit goal at the governing board level. Those that have are worth studying, because their results allow us to see that zero harm, while it might seem impossible, may actually be something we can achieve. The two organizations profiled here—Memorial Hermann Health System and Cincinnati Children’s—both exemplify what it means to work toward zero harm, and each has lessons for every healthcare organization striving for high reliability.

Memorial Hermann Health System

Around 2002, the 12 hospitals in the Memorial Hermann Health System (MHHS) began looking at ways to use clinical quality measures to achieve better care. Four years later, that want became a need. A pair of blood transfusion errors within days of each other killed one patient and left the other in critical condition. Those incidents led to a sense of urgency across the organization to improve its patient safety efforts.

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As part of its high reliability efforts, MHHS collaborated with the Joint Commission Center for Transforming Healthcare on the Center’s first improvement initiative, which targeted hand hygiene. The results were dramatic, as the average across all MHHS hospitals went from a baseline of 44% hand hygiene compliance to 92%. This was done using Robust Process Improvement®—a management system with a set of strategies, tools, and methods to define and measure the impact of a problem, discover specific causes, and create targeted solutions. Soon after

Despite the organization’s previous success with high reliability efforts, a number of high-volume physicians balked at new protocols and took their referrals elsewhere, while others lost their privileges. Still, MHHS’ results again were overwhelmingly positive. One hospital received the system’s Certified Zero Award for having no central line–associated bloodstream infections for 12 months. Five hospitals had no ventilator-associated pneumonias during that same year. Six hospitals had no retained foreign objects, seven had no serious pressure ulcers, one had no hospital-associated injuries, two had zero deaths among surgical inpatients with serious treatable complications, and two had no birth traumas.

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