The New Patient Safety Standard

To reduce errors, the Joint Commission on Accreditation of Healthcare Organizations issued new standards emphasizing patient safety.

by Isabel Perry

America is the world's recognized leader in health care, yet serious concerns persist about the safety of care being delivered to patients. In November 1999, The Institute of Medicine released a report titled "To Err is Human," which suggests health care error causes as many as 98,000 deaths per year at a cost of up to $29 billion. To add to the situation, researchers and experts on medical-error issues say only one in 10 adverse events is reported, sometimes because of the paper work and often because health care has a "blame" culture.

Health care professionals and associations looked seriously at the findings and recommendations contained in the IOM's report. As a result, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) included the new Patient Safety Standard (effective July 1, 2001) in its *Comprehensive Accreditation Manual for Hospitals: The Official Handbook*. Although the new standards focus on patient safety, the organization-wide safety initiative also includes staff and visitors.

According to Dr. Dennis O'Leary, president of JCAHO, "These standards in the very real sense, raise the bar of expectations for performance in the nation's hospitals. Very simply, patient safety needs to be Job 1 for hospitals across the country, and that's what our standards are seeking to do." Some hospitals already have made significant progress on some of the issues. Computerized physician order entry and streamlining processes to reduce acci-

dents, save time, and save money are only two areas where successes have been documented.

The new Patient Safety Standard focuses on four areas: leadership, improving organizational performance, management of information and patient rights, and education and continuum of care. The most extensive changes and additions to existing standards are in the area of leadership. The majority of the new standards are directed at hospital leaders, who must demonstrate their commitment to safety to staff, patients, and boards by encouraging communication and collaboration, educating employees and patients, and providing financial and strategic support. The new standards set a new framework that "talks" to the leaders of the organization and holds the leaders accountable for creating a safety culture.

Changes or significant additions to health care's patient safety initiatives follow.

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—Dr. Dennis O'Leary, president of JCAHO

Leadership

Leaders must ensure implementation of an integrated patient safety program throughout the organization.

- Designation of qualified individuals or an interdisciplinary group to manage the patient safety program.
- Definition of the scope of the program activities, typically ranging from "no harm slips" to sentinel events. (A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury.)
- All components of the health care organization are integrated into and participate in the organization-wide patient safety program.
- Medical/health care errors must be responded to immediately, including care of the affected patient(s), containment of risk, and preservation of information for incident analysis.
- Internal and external reporting of information relating to medical/health care errors must have defined communication systems.
- Root cause analysis is used in response to a sentinel event, or for conducting proactive risk reduction activities.
- The board of trustees, or its equivalent, must receive an annual report on the occurrence of medical/health care errors and actions taken to improve patient safety, including both reactive and proactive initiatives.

Leaders ensure that sentinel events are defined and managed to reduce repeat occurrences.

- The JCAHO's Sentinel Event Policy must be communicated throughout the organization.
- Clear channels of communication must be established and utilized in the reporting of a sentinel event.
- Investigations utilize "root cause analysis" that focuses on process and systems failures.
- Risk-reduction strategies must be documented and measured to determine effectiveness.

Leaders ensure that an ongoing, proactive program for identifying risks and reducing errors is designed and implemented.

- Proactive risk assessment activities, using available information about sentinel events known to occur in health care organizations that provide similar care and services, are a focus. Processes, functions, and services are designed or redesigned to prevent repeat occurrences.
- Potential risks to patient safety are proactively identified and managed. This approach avoids the barriers to hindsight bias and the fear of disclosure, embarrassment, blame, and punishment that can arise after the fact.
- Leaders provide direction and resources for proactive activities to reduce risk. At least one high-risk process is selected for proactive risk assessment. Root cause analysis is utilized to determine why an error may occur. Processes must be redesigned , implemented, and tested to minimize risk. Finally, a strategy for consistent utilization of the newly redesigned process must be deployed.

Leaders ensure that patient safety issues are given a high priority and addressed when processes, functions, or services are designed or redesigned.

- Health care facilities are encouraged to use their own risk management database or they may turn to a national database such as the Joint Commission's Sentinel Event Database, which has been compiled over the last six years. It identifies types of care where other hospitals have had similar problems and are equally vulnerable.

Organizational Performance

Hospitals must assess high-risk activities and develop processes to improve patient safety.

- There is a focus on good process design, where functions and services draw on a variety of information sources, both within and outside the organization. JCAHO stresses the information should include sentinel events. Failure analysis and/or pilot testing is use to determine whether the new process is an improvement.
- Data is collected to monitor performance. Organizations are required to collect data by surveying patients, families, and staff for their opinions, needs, perceptions of risks, and suggestions for improving safety. Hazardous conditions are noted, and priorities for proactive risk reduction are undertaken.
- Intense analysis is conducted when organizations detect undesirable patterns in performance and sentinel events. Priority is also given for proactive reduction in risks. Root cause analysis is performed when a sentinel event occurs. Processes are studied to learn in greater detail how they can malfunction and how errors occur.

■ The organization makes changes that will lead to improved performance and improved patient safety.

The health care industry is looking to other industries to model their successes, especially in the areas of process improvement for safety. Most notably, they are looking at the aviation industry, where the penalties for failure are significant in both human and money terms. According to JCAHO's O'Leary, "the really big deal here is the preventive analysis of patient care processes...it really involves the introduction into health care of engineering concepts, specifically, 'failure mode and critical effects analysis' that we don't do in health care.

"There are systematic approaches to taking apart vulnerable processes and building safety back into them," he continued. "What we are really seeking is a new discipline, new preventive engineering discipline, and we actually use those terms, 'the failure mode and critical effect analysis' in the standard.... It may be very unfamiliar terms to hospitals today (but) five years from now, I would hope you walk into any hospital and they would be able to describe to you exactly what that is."

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Information Management and Patients' Rights

The hospitals must utilize information management processes to meet internal and external information needs.

■ Communication processes are developed to disseminate information about safety within the hospitals and to others. Barriers to communication must be identified and eliminated. A "need to know" assessment must be conducted for all information, and where appropriate, relevant information should be accessible in a timely manner.
■ Formats and methods for disseminating information must be standardized to enable data to be transmitted quickly and accurately.
■ Medical records contain specific data to promote continuity of care among caregivers.
■ Patients and, when appropriate, their families, are informed about potential outcomes of care, including unanticipated outcomes.

Education and Continuum of Care

Information about patient responsibilities is communicated, and the hospital ensures continuity over time during the phases of service to a patient.

■ Patients are involved in the health care process by becoming educated about their roles in helping facilitate the safe delivery of care.
■ The hospital ensures coordination among health care professionals and services involved in a patient's care.
■ In-service and other training is provided to support an interdisciplinary approach to care. Information should emphasize specific job-related aspects of safety and should include team training to foster a collaborative approach to health care.

Although the health care industry has been criticized for its results in patient safety, JCAHO has provided a "roadmap to success" for quantum improvement in hospitals' safety initiatives. Safety professionals throughout the country can contribute to this safety effort by sharing their "best of class" successes in overlapping areas of responsibilities, regardless of the industry.

All of our work environments may not be similar, however, safety systems analysis, safety process improvements, and behavioral change transcend into any work environment. ■

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References

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