Achieving Zero Harm

The Joint Commission's First Patient Safety Officer Shares His Insights

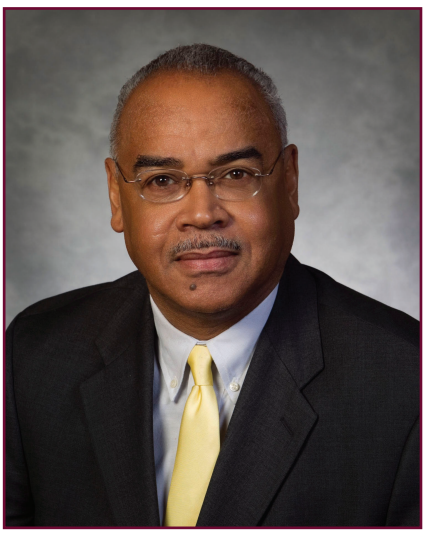
A Q&A with Ronald Wyatt, MD

In February 2016 Ronald Wyatt, MD. was named The Joint Commission's first patient safety officer. The newly created position reflects the organization's commitment to promoting a safe and high-quality health care system with a goal of zero patient harm. Wyatt also serves as The Joint Commission's Medical Director in the Division of Health Care Improvement. The following interview discusses his perspective on key patient safety issues and the effort of health care organizations to get to zero.

THE SOURCE: *Do you believe that achieving zero patient harm is an achievable goal?*

WYATT: I believe that zero *preventable* harm is achievable. Now, that doesn't mean we can totally eliminate error. It doesn't mean we can totally eliminate mistakes. It's important to understand that some harms are not preventable. For instance, if I need to stick your artery for an arterial blood gas, that is an intentional harm. If I need to give you chemotherapy for a cancer and

(continued on page 11)



Ronald Wyatt, MD

you lose your hair, that's unavoidable. But zero preventable harm is achievable.

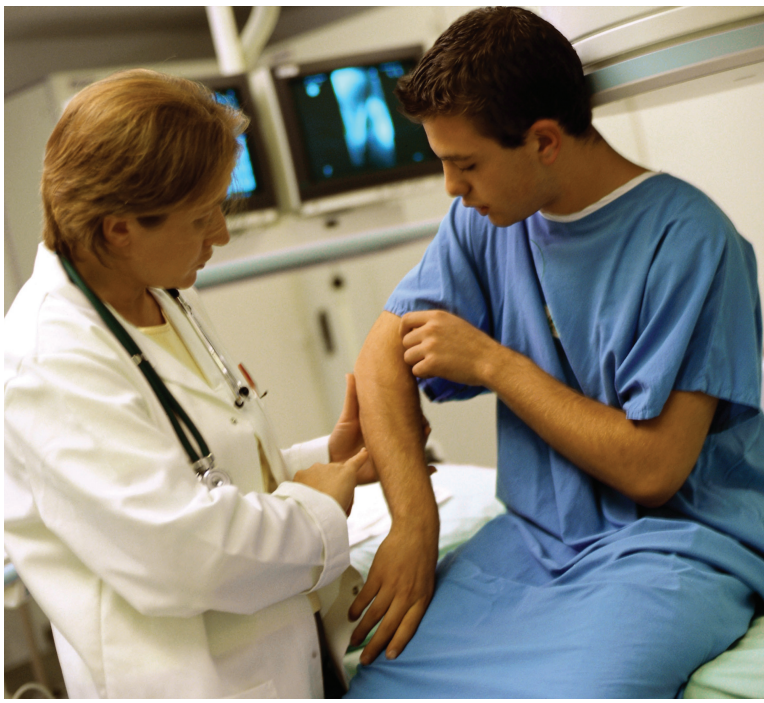
During the last decade or so there are organizations that have achieved zero in areas such as falls with injury, blood transfusions, and so forth, so I think we are years beyond saying we cannot achieve zero. It's more than an aspirational statement, particularly as it relates to patient safety. We now know, thanks to a lot of effort by patient safety experts and people smarter than me, that there is a path with some common approaches that will get you to zero.

It is a mark of excellence in a leader who says, "That is what we aim for. We will get to zero." I think as leaders in health and health care, we have to say that courageously and repeatedly, and then start to work towards zero in a strategic way. So it's more than a slogan. More than a banner. More than a T-shirt. It is hard work.

THE SOURCE: *What are the most important factors that influence a health care organization's journey toward zero patient harm?*

WYATT: There has to be a strategic, structured approach. Also, I think embedded in that is some kind of method; some kind of operational excellence. There should be an approach that an organization is resourced with, whether that is a Robust Process Improvement® or some other approach.* That knowledge needs to be provided by leadership. Give people the knowledge. It's difficult to say you can get to zero when a system needs certain inputs around knowledge and around culture change that you are not providing.

If you look at the "Patient Safety Systems" chapter in the *Comprehensive Accreditation Manual for Hospitals*, it lays everything out. (Editor's note: As of January 2017 this chapter will also appear in the Ambulatory Health Care Critical Access Hospital accreditation and office-based surgery manuals.) It tells you that one factor is the role of leadership. Leadership being accountable. Leadership being present. Leadership providing the right kind of environment for the care teams in the first place. Leadership establishing a culture of safety. Leadership doesn't just mean the chief medical officer and the chief executive officer, it means the chief nursing officer and the chief finance officer who is a key lever in any attempt to get to zero. At the very top, the board of directors has to be fully on board with the initiative because they have the fiduciary responsibility for safety at an organization. They should be tightly aligned with the organizations leaders on the strategy. After you have a strategy and an organizational alignment, then you have to think about how to execute the strategy.



The Joint Commission is increasingly focused on patient safety and performance improvement.

THE SOURCE: *How would you define the concept of safety culture?*

WYATT: A prerequisite for getting to zero is making sure you have a safety culture. It's a huge challenge for many organizations. The term, *just culture*, is often overused, but a just culture alone won't get you to zero. It has to exist, but if you go back to the origins of safety culture, there's more there than a just culture.† You have to have a learning culture, a reporting culture, a culture that has built into it psychological safety. You have to have a culture that not only recognizes unprofessional behavior, but has a mechanism in place to correct that behavior because of the risks it can

(continued on page 12)

* For a definition and discussion of Robust Process Improvement, see Chassin MR, Loeb JM. The ongoing quality improvement journey: Next stop, high reliability. *Health Aff* (*Millwood*). 2011 Apr;30(4):559–568. Accessed Aug 10, 2016 http://content.healthaffairs.org/content/30/4/559.full?ijkey=UoA7j1SNli6pQ&keytype=ref&siteid=healthaff.

† For a discussion of the "just culture" approach, *see* The Joint Commission. Patient Safety Systems Chapter for the Hospital Program. Jan 5, 2016. Accessed Aug 10, 2016. https://www.jointcommission.org/patient_safety_systems_chapter_for_the_hospital_program/

cause.

When we think about getting to zero, the safety culture is vital. We don't want a punitive culture or a culture that blames and shames, intimidates and throws up barriers . . . we want a culture that recognizes that there are blame-free events and events that are blame-worthy. They both have to be addressed inside a just culture. [*See* the sidebar below for further discussion of *safety culture.]*

In many organizations the leaders will blame the staff for whatever goes wrong. They fail to listen. In some places it's hard to find out who's in charge because leaders won't accept the responsibility. Or they decide to have a standard operating procedure based on rules and not on being engaged. Or they do something that defies everything in patient safety—they suppress the patients' voice. How in the world can you talk about getting to zero if you don't hear what the patients have to say? So you have to have a high level of personal accountability. You have to have built-in safety values, a communication approach and respect. You have to understand the environment you are putting

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> ***—Ronald Wyatt, MD***

Understanding Safety Culture

A strong safety culture is an essential component of a successful patient safety system and is a crucial starting point for health care organizations striving to become learning organizations. In a strong safety culture, the organization has an unrelenting commitment to safety and to do no harm. Among the most critical responsibilities of leaders is to establish and maintain a strong safety culture within their organization. The Joint Commission's standards address safety culture in Leadership (LD) Standard **LD.03.01.01**, which requires leaders to create and maintain a culture of safety and quality throughout the hospital.

A health care organization's *safety culture* is the product of individual and group beliefs, values, attitudes, perceptions, competencies, and patterns of behavior that determine the organization's commitment to quality and patient safety. Organizations that have a robust safety culture are characterized by communications founded on mutual trust, by shared perceptions of the importance of safety, and by confidence in the efficacy of preventive measures. Organizations will have varying levels of safety culture, but all should be working toward a safety culture that has the following qualities:

- Staff and leaders that value transparency, accountability, and mutual respect
- Safety as everyone's first priority
- Behaviors that undermine a culture of safety are not acceptable, and thus should be reported to organizational leadership by staff, patients, and families for the purpose of fostering risk reduction.
- Collective mindfulness is present, wherein staff realize that systems always have the potential to fail, and staff are focused on finding hazardous conditions or close calls at early stages before a patient may be harmed. Staff do not view close calls as evidence that the system prevented an error but rather as evidence that the system needs to be further improved to prevent any defects.
- Staff do not deny or cover up errors but rather want to report errors to learn from mistakes and improve the system flaws that contribute to or enable patient safety events
- Staff know that their leaders will focus not on blaming providers involved in errors but on the systems issues that contributed to or enabled the patient safety event.
- By reporting and learning from patient safety events, staff create a learning organization.

Source: The Joint Commission. *Patient Safety Systems.* 2016 Jan. Accessed Aug 3, 2016. https://www.jointcommission.org/patient_safety_systems_chapter_for_the_hospital_program/.

people in.

You want a culture in which they tell you at train stations, "If you see something, say something." You have to be in a culture where the early warning signs are recognized as signals and not anomalies. A culture trying to get to zero recognizes those signals as opportunities. You use those opportunities to find out why something in the system went wrong. Are there risks that the system, for one reason or another, has decided to accept? If you start to accept risk then you start to drift into failure.

THE SOURCE: *What actions can organizations take to assess and improve their culture of safety?*

WYATT: One of the key things to do is to have a structured reporting system that receives the signals of potential failure and measures culture. I often hear people say they can't measure culture, but you absolutely can measure it. Some of the things you can readily do is identify what your harm rate is. You can identify what is your adjusted mortality rate and ask how does it compare to your benchmark? What is your care team injury rate? What is your employee turnover rate? How often do you use contract employees and where do you use them? Do you have teamwork training? Are you doing executive rounds? Have you put safety teams on a unit or floor? For instance I visited one organization with a patient safety technician on a unit, and that person reinforced patient safety all day, every shift. They kept track of fall rates and hourly rounding, so they had a structured way to measure their safety. All of the things I just mentioned can be measured.

If you spend a lot of time like I do on airplanes, you see that there is a structured communication approach, from the minute you get to the waiting area. It continues after you are on the airplane. They hand you a safety card to show you how to protect yourself if something goes wrong on the flight. They check to see if your seat belt is buckled. If you sit in an exit row the attendant is going to get in your face and ask if you understand what your responsibilities are. Why shouldn't a health care environment function the same way? This kind of structured communication approach is something that needs to be in place at organizations.

THE SOURCE: *How do Joint Commission standards and the survey process support organizations in their efforts to improve patient safety?*

WYATT: The reason I'm here is because of The Joint Commission's efforts and activities to address safety issues. We are increasingly focusing on patient safety and quality improvement, and we boldly say that the goal is zero. We're

A robust system for reporting patient safety events is a cornerstone of an effective patient safety system.

in the midst of transforming our survey with more focus on safety, using data and making sure organization leaders understand that we are getting away from a punitive, "I gotcha" attitude.

When we started to write the "Patient Safety Systems" chapter, which is now available to the public, we started to look to see if we needed any new standards. We realized that everything was already in The Joint Commission accreditation process. The challenge was that it was scattered all over the place. So we pulled together the components and standards that are valuable to leaders; that help them achieve the goal of not hurting anyone. And then we included all the standards in the "Patient Safety Systems" chapter. We can use that chapter as a framework, as a guide, as a blueprint for leadership. The language builds on the standards, and that is what the surveyors are being trained with and what they refer to.

(continued on page 14)

Right now we are close to developing a patient safety tracer that will be used by surveyors. It will be directed at leadership so that after the survey is complete, and even during the survey process, leadership and those involved in the survey will receive constant real-time feedback on their safety status. That is an enormous educational project for the surveyors that adds tremendous value to the organization they survey. It isn't designed to show people what they've done wrong, but to work with them in a collaborative way to see what their most critical risks are as they are identified during surveys.

The Joint Commission wants to be proactive. A lot of what takes place in health care in general is a reactive approach. In other words, after something happens they figure out how to improve. But what we're talking about is a proactive approach that we think will lead to higher levels of reliability. By *reliability* we mean a continued decrease of failure rates over time. No one is going to wake up tomorrow and have zero harm, but by putting in fail-safes, redundancies and processes, and creating the kind of work environment that decreases the possibilities of errors and increases collective mindfulness, they can get to zero. It's not as important to know how we get out of trouble, but how we stay out of trouble in the first place. Understanding these factors allows us to learn from mistakes and come back from them stronger than before. That's the path to get to zero.

THE SOURCE: *You were recently named The Joint Commission's first patient safety officer. What is your role in this new capacity?*

WYATT: My role is to attempt to manifest the vision of The Joint Commission. In order for us to better promote patient safety and quality improvement, we needed to have a patient safety officer whose job is to focus on patient safety rather than standards compliance. We need to build relationships with organizations, to build trust and talk about the things that aren't easy to talk about. Having someone out there who is expert enough to have those conversations is important. Almost every time I go to talk to folks or visit a health care organization, there are usually only one or two questions during a session, but when I'm trying to get to a taxi there are a bunch of folks who want to say something. They are just afraid to do that in the health care setting. A lot of what I hear is, "I'm so glad you said that because it needed to be said. And The Joint Commission needed to be the one to say it."

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I also hear from organizations who ask me to come talk to the medical staff about safety because they are afraid to. Their culture just doesn't allow for them to do that. But they believe staff will listen to me and come to understand that the safety efforts they've been advocating are meaningful and represent what's best for their patients.

We probably won't get to absolute zero in my lifetime, but a measure of success for me would be to eliminate the need for a patient safety officer. I'd like to see health care organizations improve their safety cultures and communication and get on a path toward no patient harm. Let me work my way out of a job. TS