Panel Discussion

The Integration of Information Technology, Quality and Patient Safety

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Mission of Joint Commission International

- To improve the safety and quality of care in the international community
  - through the provision of education, publications, consultation, evaluation, and accreditation services

International Patient Safety Movement

- WHO World Alliance for Patient Safety (Launched October 2004)
  - Global Challenges
    - 2005-2006 Clean Care is Safer Care
    - 2007-2008 Safe Surgery Saves Lives

International Patient Safety Movement

- Patients for Patient Safety
- Reporting and Learning
- Taxonomy for Patient Safety
- Research for Patient Safety
- Safety Solutions
  - JCI is the international collaborating center for patient safety solutions

Primary Tasks

- Clear tasks
  - Obtain leadership commitment
  - Reduce risk in health care processes
  - Change behaviors to lower risk
- Less clear tasks
  - Understand and obtain commitment to IT as part of safety
  - Charting the IT course for safety

Where is IT Needed?

- Reducing risk of infections
  - Hand washing program –NO
  - Demonstrating effectiveness of the program – YES
- Reducing medication errors
  - Policy on use of abbreviations – NO
  - Use a medication order entry system that will not accept abbreviations - YES

Leap or Limp Into the Future

- LEAP – the paperless hospital with comprehensive electronic medical record
- LIMP – incremental enhancements to existing systems

Considerations for Either Approach

- System Thinking – just as health care delivery represents an interlocking set of systems, thus IT must also be one comprehensive system
- Create a Learning System - capture "events" not just data
  - Make reporting safe
  - Provide real time information
  - Understand accountabilities

Considerations for Either Approach

- Link Systems – internal and external comparative data is essential

- Focus on Risks with Proven Solutions-
  - Positive patient identification
  - Communication among caregivers
  - Safe medication practices

Strategies for Progressive Changes

- Equip existing systems with checks and balances, alarms and alerts
- Make the reporting of events easy for staff by locating input devices where the events occur
- Keep up with process redesign which is the foundation of continuous improvement

Strategies for Progressive Changes

- Combine or collapse key quality and risk organizational structures for more efficient management of information
- Consider the continuum of care and enable IT systems to follow patients

Strategies for Progressive Changes

- Include outsourced services in key databases
- Provide patients, families and communities with quality and safety data

Example - Sentinel Event Data

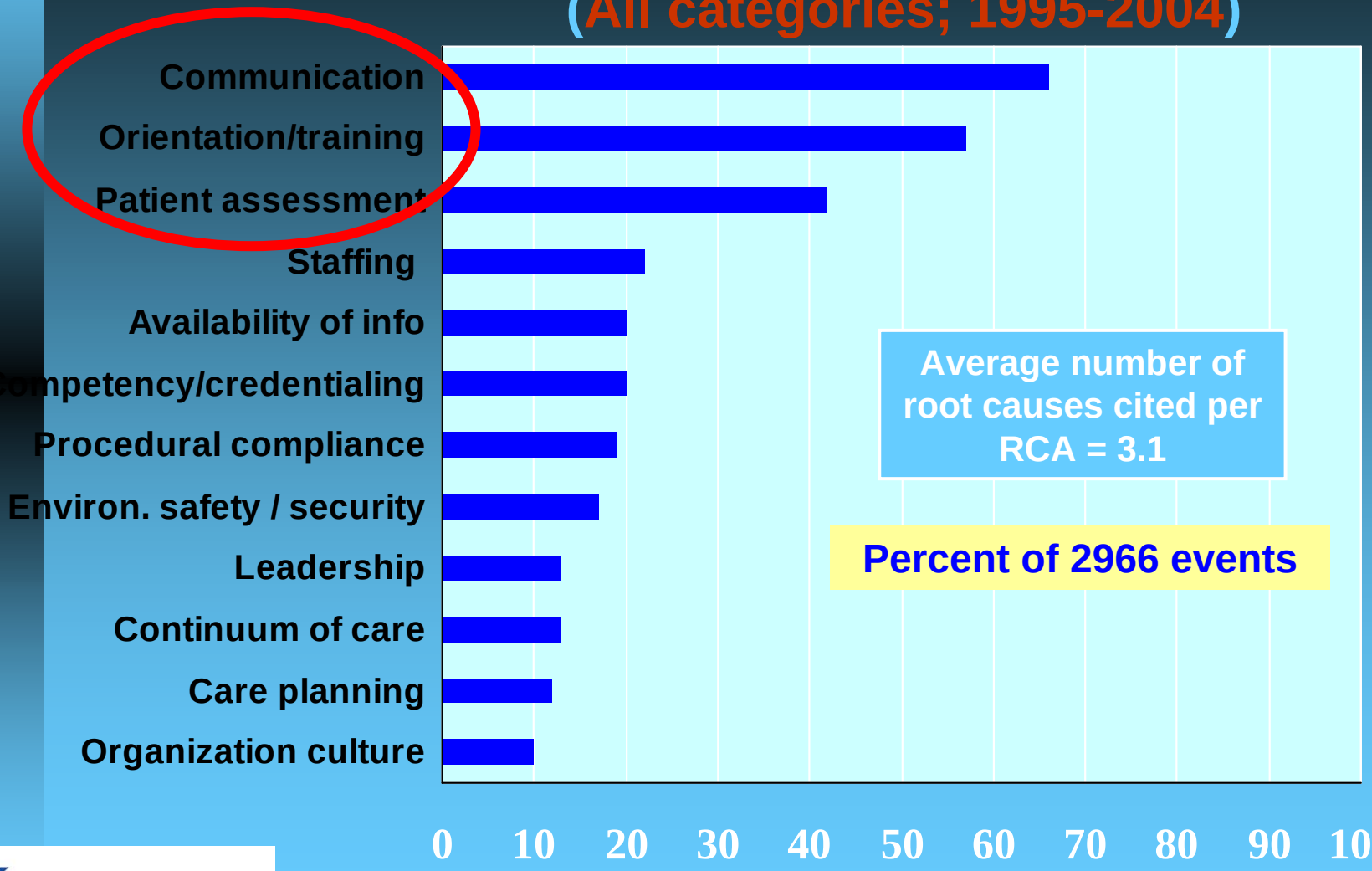
Of 4064 sentinel events reviewed by the Joint Commission, January 1995 through December 2006:

531 events of wrong site surgery
520 inpatient suicides
488 operative/post op complications
385 events relating to medication errors
302 deaths related to delay in treatment
224 patient falls
153 deaths of patients in restraints
138 assault/rape/homicide
125 perinatal death/injury
94 transfusion-related events
85 infection-related events
72 deaths following elopement
66 fires
67 anesthesia-related events
51 retained foreign objects
763 "other"

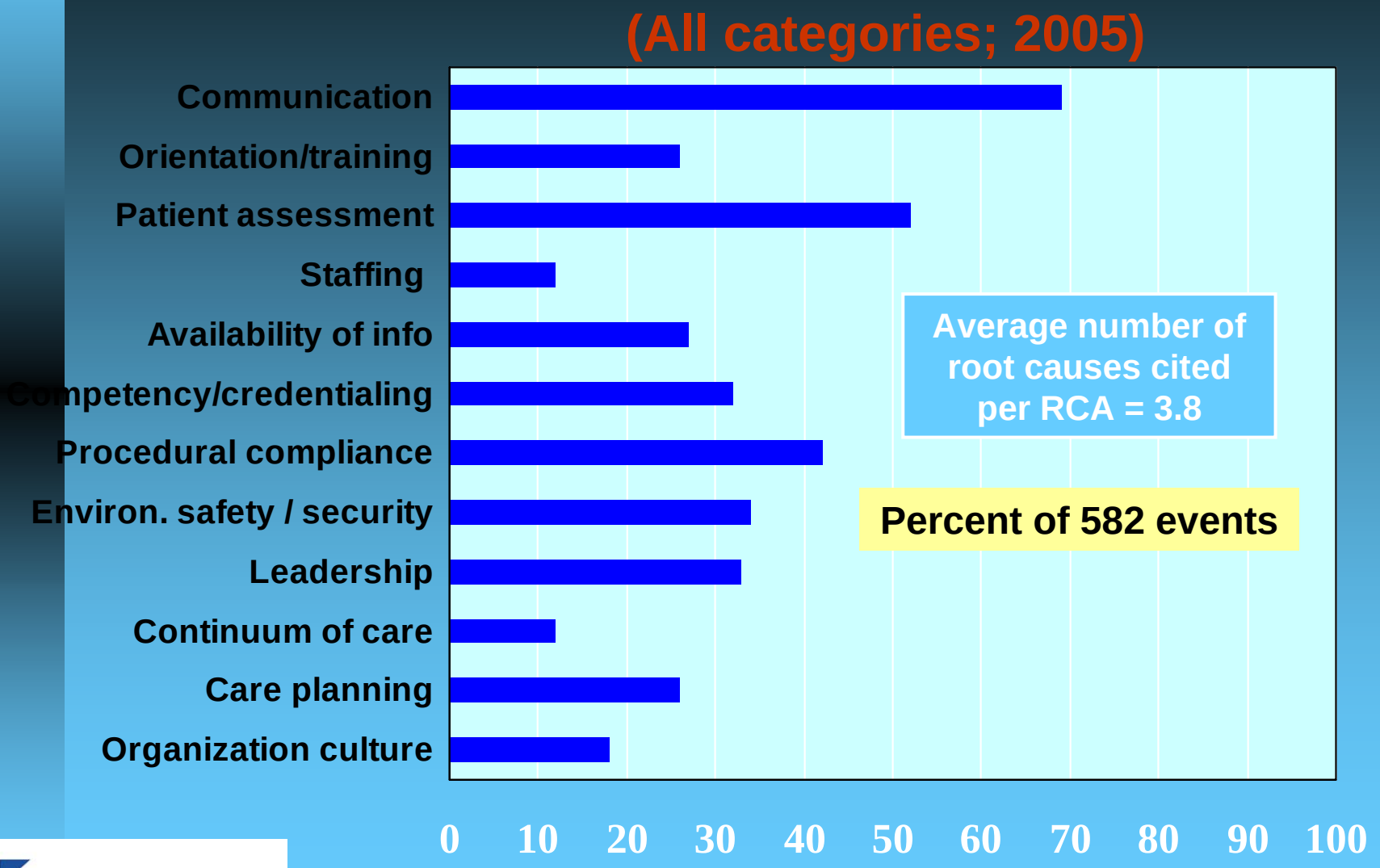
= 4064 RCAs

Root Causes of Sentinel Events

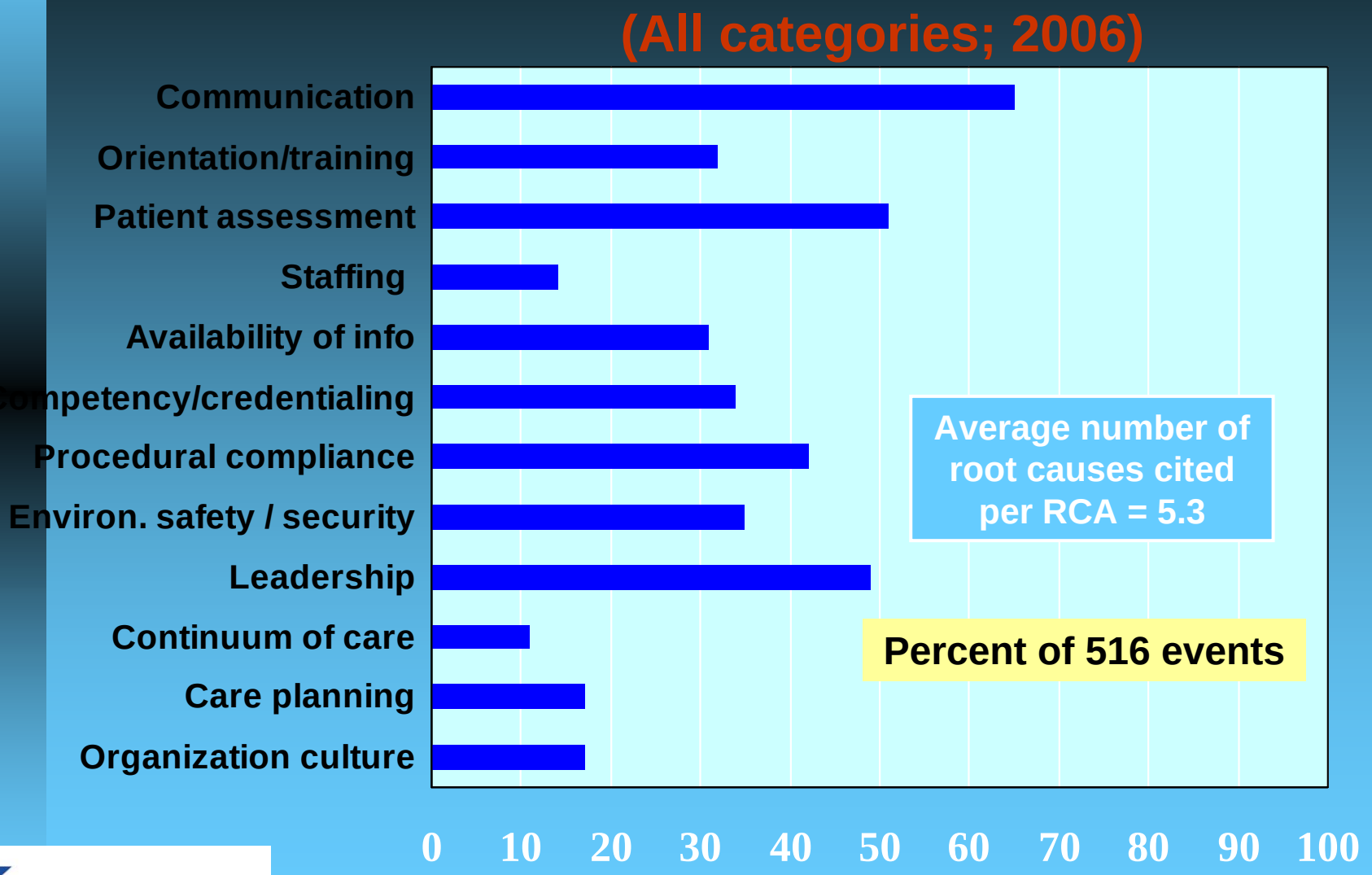
(All categories; 1995-2004)



Root Causes of Sentinel Events

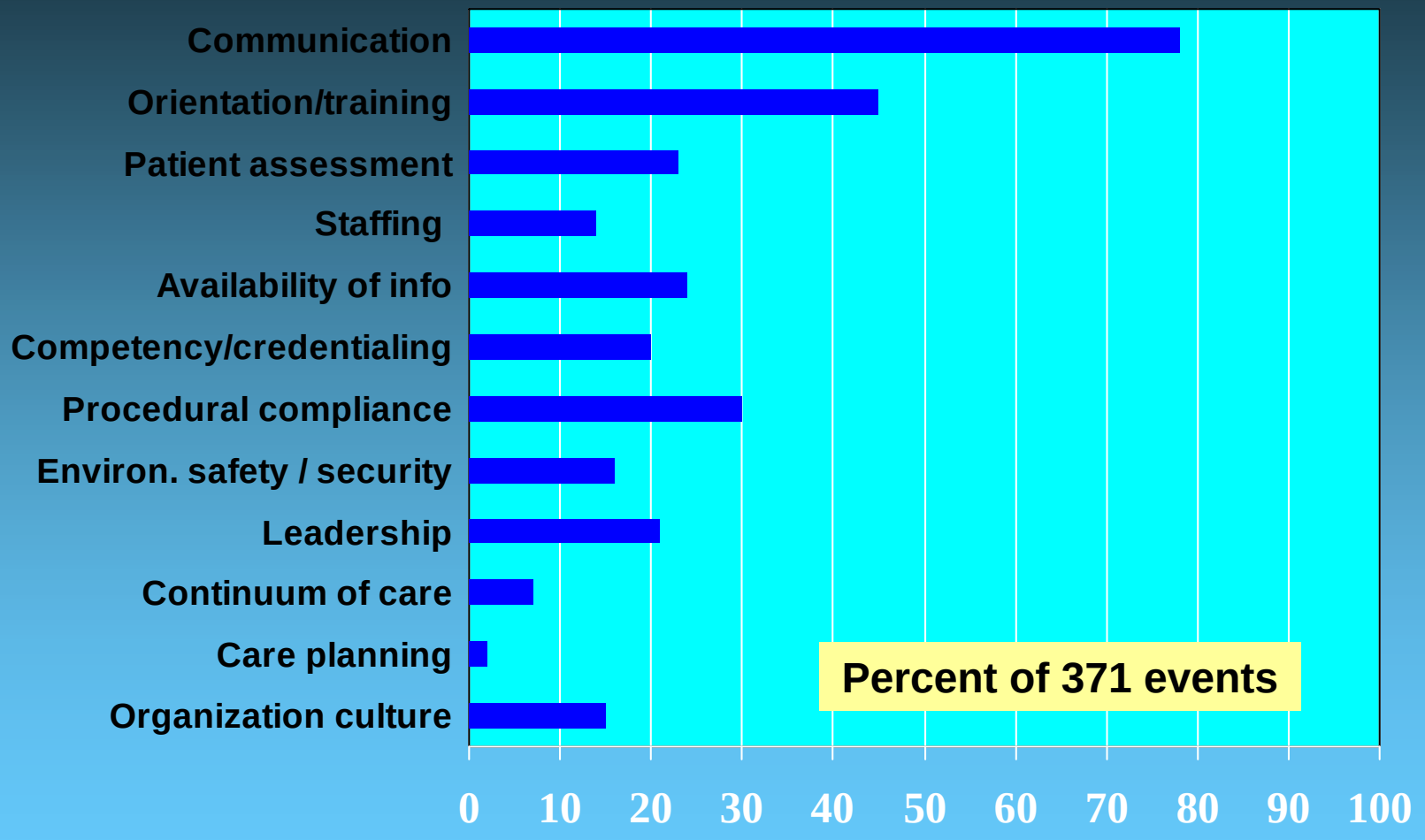


Root Causes of Sentinel Events



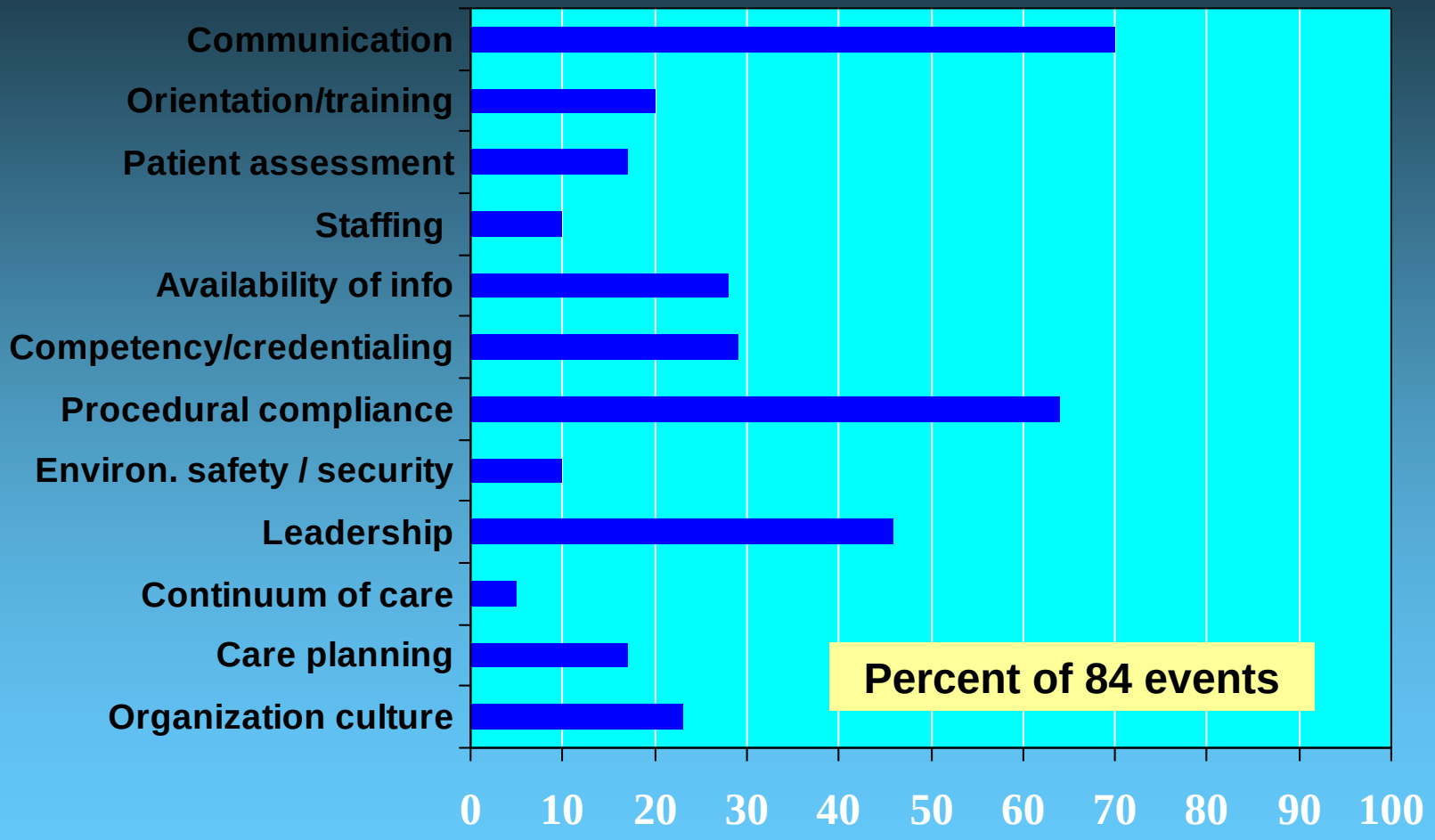
Root Causes of Wrong Site Surgery

(1995-2004)

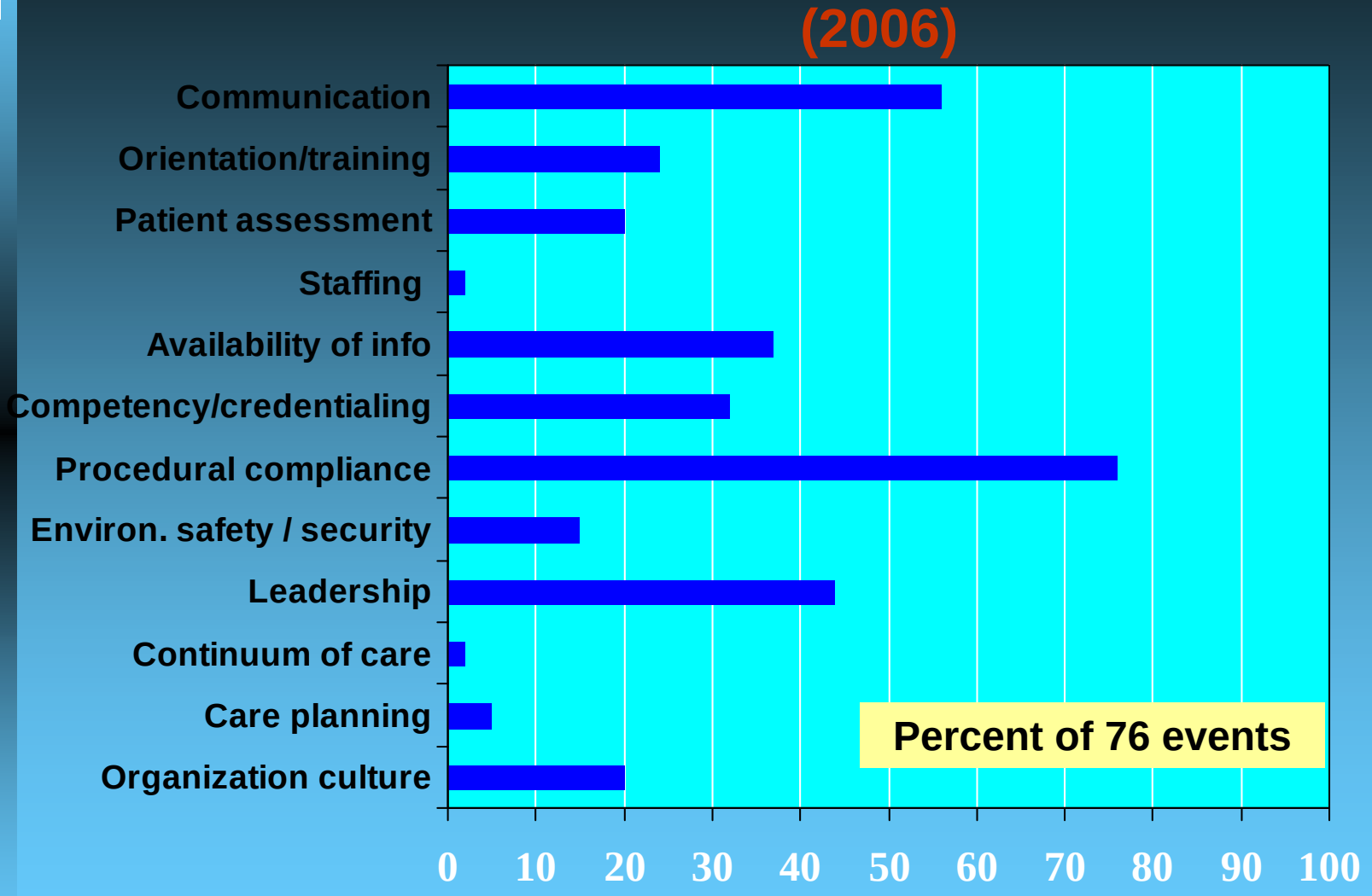


Root Causes of Wrong Site Surgery

(2005)



Root Causes of Wrong Site Surgery



SENTINEL EVENT***ALERT***

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"The way to prevent tragic deaths from accidental intravenous injection of concentrated KCl is excruciatingly simple - -organizations must take it off the floor stock of all units. It is one of the best examples I know of a 'forcing function' -- a procedure that makes a certain type of error impossible."
Lucian L. Leape, M.D.

New Publication

We are pleased to introduce the first issue of *Sentinel Event Alert,* a periodic publication dedicated to providing important information relating to the occurrence and management of sentinel events in Joint Commission-accredited health care organizations. *Sentinel Event Alert,* to be published when appropriate as suggested by trend data, will provide ongoing communication regarding the Joint Commission's Sentinel Event Policy and Procedures, and most importantly, information about sentinel event prevention. It is our expectation and belief that in sharing information about the occurrence of sentinel events, we can ultimately reduce the frequency of medical errors and other adverse events.

Medication Error Prevention -- Potassium Chloride

In the two years since the Joint Commission enacted its Sentinel Event Policy, the Accreditation Committee of the Board of Commissioners has reviewed more than 200 sentinel events. The most common category of sentinel events was medication errors, and of those, the most frequently implicated drug was **potassium chloride (KCl)** The Joint Commission has reviewed 10 incidents of patient death resulting from misadministration of

Concluding Comments

- Make IT part of the quality and safety team – management walk rounds are an effective strategy
- The desired end result is an organizational culture of safety
  - Continual learning from events
  - Openness and lack of fear
  - Teamwork and open communications among all staff

Concluding Comments

- The foundation of the JCI accreditation process is risk reduction
  - International consensus standards
  - International patient safety goals
  - International best practices
  - International performance measures

Thank You

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