Sustaining Top Performance on Joint Commission Accountability Measures

(OAK BROOK, Illinois, February 2, 2016) – Joint Commission Resources, Inc., today released the February 2016 issue of The Joint Commission Journal on Quality and Patient Safety. The issue features an article, “Sustaining Reliability on Accountability Measures at The Johns Hopkins Hospital,” by Peter J. Pronovost, MD, PhD, and coauthors, on how Johns Hopkins Hospital (JHH), Baltimore, sustained its success in earning recognition from The Joint Commission’s Top Performer on Key Quality Measures® program for performance in 2012 by achieving such recognition again for performance in 2013. Few studies have addressed how to sustain quality improvement efforts, making this article an important contribution. The article’s focus on sustainability is reflected in a detailed, step-by-step how-to guide for other hospitals to use in developing or improving their own sustainability processes.

The hospital’s leadership challenged the health system to reliably deliver best practice care linked to nationally vetted core measures to achieve Top Performer recognition and the Delmarva Foundation award. In response, the Armstrong Institute for Patient Safety and Quality at Johns Hopkins Medicine implemented an initiative to ensure that 96 percent or more of patients received care linked to measures. Nine low-performing process measures were targeted for improvement—eight Joint Commission accountability measures and one Delmarva Foundation core measure.

The sustainability process entailed declaring and communicating goals, creating an enabling infrastructure, engaging clinicians and connecting them in peer learning
communities, reporting transparently, and creating accountability systems to establish reliable processes of care for the measures.

Through this initiative, JHH was able to have quality improvement make the transition from isolated projects to a way of leading an organization.

The remaining articles from the February 2016 issue are:

**Performance Improvement**

**Engaging Frontline Staff in Performance Improvement: The American Organization of Nurse Executives Implementation of Transforming Care at the Bedside Collaborative**

*Jack Needleman, PhD; Marjorie L. Pearson, PhD, MSHS; Valda V. Upenieks, PhD, MPH, RN, NEA-BC; Tracy Yee, PhD, MPH; Joelle Wolstein, PhD, MPP, MA; Melissa Parkerton, MA/ABS*

In a 15-month American Organization of Nurse Executives 67-hospital collaborative, Transforming Care at the Bedside (TCAB), all units reported establishing unit-based teams, of which more than 90 percent conducted tests of change. An average 36 tests of change were conducted per unit; 46 percent of tested innovations were sustained and 20 percent spread to other units. TCAB appears to be a productive model for organizing and implementing a program of frontline improvement.

**The Contribution of Sociotechnical Factors to Health Information Technology–Related Sentinel Events**

*Gerard M. Castro, PhD, MPH; Lisa Buczkowski, MS, RN, CPPS; Joanne M. Hafner, MS, RN*

For 3,375 de-identified sentinel events voluntarily reported to The Joint Commission (January 1, 2010–June 30, 2013), 120 health information technology–related sentinel events (affecting 125 patients) were identified. More than half resulted in patient death, 30 percent resulted in unexpected or additional care and 11 percent resulted in permanent loss of function. The sentinel events were primarily associated with the sociotechnical dimensions of human-computer interface, workflow and communication, and clinical content.
Care Processes
Redesigning the Patient Observer Model to Achieve Increased Efficiency and Staff Engagement on a Surgical Trauma Inpatient Unit
Pratik Rachh, MD, MBA, CSSBB, CPHQ; Gianna Wilkins, BS; Theresa A. Capodilupo, RN, MSN; Susan Kilroy, MS, RN; Maureen Schnider, MS, RN, NE-BC, CPHQ; Jennifer Repper-Delisi, RN, MSN, PMHCNS-BC

Providing safe and efficient observer care to inpatients whose behavior puts them at risk for injury is a clinically challenging and costly endeavor. At Massachusetts General Hospital, Boston, an innovative process was created to identify, assess and develop best practices for ensuring safety for patients with delirium. The median number of patient observer direct-care hours decreased from 208 (January 1, 2012–July 13, 2013) to 112 (July 14, 2013–June 28, 2014) hours/week—a 46 percent decrease in utilization—and the fall rate remained unchanged.

Case Study in Brief
Recommendations and Low-Technology Safety Solutions Following Neuromuscular Blocking Agent Incidents
Linda V. Graudins, BPharm, DHP, GradDipClinEpid; Glenn Downey, MBBS; Thuy Bui, BPharm, MClin Pharm; Michael J. Dooley, BPharm, GradDipHospPharm, PhD

Three cases of non–operating room drug-swap cases involving cisatracurium were reported within a year at a teaching hospital in Australia, resulting in a comprehensive review of neuromuscular blocking agent safety. A root cause analysis resulted in multiple interventions to decrease the risk of selection and administration errors. Four years later, no cisatracurium-selection error has been reported.

Forum
Lessons Learned on a Journey from Surgeon to Chief Quality Officer
J. Michael Henderson, MD

Dr. Henderson provides lessons from his experience as a chief quality officer that may
inform the work of physicians and other health care professionals, whether they are engaged in or are leading patient safety and quality efforts.

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