Taking Aim at the Right Targets

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Despite past efforts to improve patient safety—and there has been effort and activity aplenty—routine safety processes continue to fail routinely. Poor hand hygiene remains a major vector of health care-associated infection. Medication errors lead to adverse drug events with alarming frequency. Transitions in care often introduce new opportunities to harm patients. Less common but entirely preventable events such as wrong site surgery and retained foreign objects following surgery, to name just two, have not abated despite major efforts aimed at eliminating them. This lackluster history of combating preventable harm to patients may not be due to the fact that we have the wrong solutions. Rather, we have not fully understood the problems that the solutions are meant to address.

We have tended to rely on best practices, toolkits, protocols, checklists, and solution bundles as if they are magic bullets. These generalized approaches are most successful when a process, such as insertion of central lines in ICU patients, varies little from place to place and the causes of failure are few and common. Such circumstances are rare. Most persistent safety problems are laden with greater complexity and variation. Addressing these requires an approach that can uncover the many underlying causes of the same problem, recognize the variability in underlying causes from place to place, and customize solutions to directly target the factors in play.

Using just such an approach, the Joint Commission Center for Transforming Healthcare has been collaborating with leading health care organizations to uncover the underlying causes of patient safety problems and create customizable solutions since its inception in 2009. Recently, the Center released the results from its Wrong Site Surgery Project. Five hospitals and three ambulatory surgery centers collaborated on the project. All had to study their own processes, from surgery scheduling to the time of incision, to ascertain the factors that increased the risk of wrong site surgery within their organizations. None had the same set of risk factors. The same variability has been documented in all of the Center’s projects, whether the issue is hand hygiene, hand-off communications or surgical-site infections.

In all, the wrong site surgery project team uncovered 29 underlying risk factors for wrong site surgery. The project team developed more than 35 solutions to address each of these factors. Each of the eight organizations tackled its own set of risk factors with solutions targeted to those risks. Taken together, so far they have reduced the risks for wrong site surgery by 46 percent in scheduling, 63 percent in the preoperative area, and 51 percent in the operating room, and are working to improve even more.
Improving performance absent the knowledge of what is specifically wrong is like flying blind. For instance, a standardized “time out” in the operating room addresses several risks associated with wrong site surgery. Yet, a well-conducted “time out,” even when enforced with a checklist, may not protect a patient whose mistake-ridden documentation makes its way into the operating room undetected. Eliminating the risks introduced by faulty documentation requires a different set of solutions. By uncovering underlying causes of patient safety problems, the Center and its many collaborators are able to succeed at improvement in the face of prior failures by deploying solutions that are targeted precisely to those causes.

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Note: Authored commentaries in this IOM Series draw on the experience and expertise of field leaders to highlight health and health care innovations they feel have the potential, if engaged at scale, to foster transformative progress toward the continuously improving and learning health system envisioned by the IOM. Statements are personal, and are not those of the IOM or the National Academies.

In his commentary, Mark Chassin describes the promising results from the Wrong Site Surgery Project of the Joint Commission Center for Transforming Healthcare. His discussion touches on several issues and lessons central to the delivery of care that is effective, efficient, and continuously improving, including the importance of:

- Continuous monitoring and feedback to identify and address performance shortfalls.
- Starting with best practices in establishing basic system standards, but thoroughly assessing and accounting for site-specific factors in play in a given institution.
- Establishment of means reporting and sharing experiences among institutions.

Information on the IOM’s Learning Health System work may be found at www.iom.edu/learninghealthsystem.