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.
JCI Accreditation Global Footprint

August 1, 2019
71 Countries
1030 Accredited Organizations
Global Accredited Organization Growth

Growth in JCIA Accreditations
[2014 thru 1 Aug 2019]

Year
Total No. Accreditations
696 784 887 970 1008 1030
JCI Accreditations/Certification – Middle East

Accreditation and Certification Programs
[Total = 399]

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<th>Program</th>
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JCI Accreditations by Program – Lebanon

Accreditation Programs - Lebanon

- Hospital, 3
- AMB, 1
- AMCH, 1
Getting to Zero Harm
Current State of Quality

- Routine safety processes fail routinely
  - Hand hygiene
  - Medication administration
  - Patient identification
  - Communication in transitions of care

- Uncommon, preventable adverse events
  - Surgery on wrong patient or body part
  - Fires in ORs, retained foreign objects
  - Infant abductions, inpatient suicides
High Reliability Organizations

- High reliability is the consistent performance at high levels of safety over long periods of time (Chassin, Loeb 2011)
- Nuclear power, aviation, petroleum and chemical industries, aircraft carriers, wildfire fighting, space flight
- Where failure to perform can mean the death of some or all of the team
Traits of HROs

- Believe anything can and will go wrong (engineers) vs. nothing will go wrong (medical)
- Focus is on reliability
- It is a mindset and a culture
- The state of high reliability is never complete or perfect
More HRO Traits

- HROs seek to know what they do not know
- They aggressively avoid organizational hubris
- They design redundant systems
- They proactively share learning and information throughout the organization
- They break down the silos
HRO Traits continued

- It is NOT:
  - A consensus culture
  - An organization focused on success
  - An organization focused on hierarchy

- High Reliability in health care:
  - Very limited experience
  - The path to success not clear
  - But some organizations are striving
Crucial Elements of High Reliability

- Leadership
  - Board, CEO, other leaders
- Safety Culture
- Robust Process Improvement
  - Understand the methods, train staff
Leadership

- Leader commitment is essential
- The leader must:
  - Understand the how and why of current operations, systems
  - Create a vision for the desired state
  - Be disciplined to sustain change
  - Commit to own growth and learning
  - Walk in the patient experience
  - Create an environment for tough questions
- Leadership and cues
A Safe and Just Culture

- Components of a safe culture:
  - Trust
  - Transparency and reporting
  - Improvement
- A Just Culture
  - Blameless errors versus blameworthy errors
  - Fairness key here
Robust Process Improvement

- Lean
  - Eliminate waste
- Six Sigma
  - Reduce defaults
- Change Management
  - Key component: WIIFM
Why Is Safety Culture So Important?

- Patients
  - They should not have to worry
- The Business Case
  - Errors are costly; payers are pushing back
  - A safe culture is the feedback loop for constantly improving
Leaders and Safety Culture

The high performing health care leader recognizes the importance of creating and sustaining a safe culture.
What is Meant by Blame Free?

- Need a clear blame free policy:
  - Employees not blamed for honest mistakes or errors in judgment
  - Critical to have near misses reported regularly – you need to create an environment where everyone feels safe making these reports
  - You can’t fix a problem you do not know exists
What is a Just Culture?

- Understands difference between and among:
  - Human error: interruptions, distractions, multitasking
  - At-risk behavior: complacency
  - Reckless behavior: incompetence, substance abuse
- Response is not related to severity of the error or whether there was harm to the patient
Human Error Versus Systems Error

- Too much focus on human element
- Root cause analysis, failure mode and effects analysis
- Determine human error or systems error
- Most errors result from bad systems
Key features of a safety culture program

• Acknowledges high-risk nature of hospital’s activities
• Individuals are able to report errors or near misses without fear of reprimand or punishment;
• Collaboration across ranks and disciplines to seek solutions to patient safety problems; and
• Committed staff time, education, a safe method for reporting issues, etc., to address safety concerns.
JCI Safety Culture Standards Compliance

- Have a patient safety plan
- Develop an annual report card
- Have a patient safety committee
- Educate all staff – near miss is an error
  - Do we agree?
- Engage the board
- Engage the medical staff
Safety Culture Standards Compliance

- Support employees when there is an event
- Hold all team members accountable for modeling desirable behaviors
- Develop organizational process to address intimidating and disruptive behaviors
Leadership’s Role

- Monitor compliance with the safety culture standards
- Provide people and other resources
- Spend time on this; make it clear this is a priority
- Coach, inspire, communicate, motivate; a good CEO is acutely aware of the risks involved and is not irrationally optimistic that everything is ok
- Leaders give the signals on safety culture
This presentation is current as of August 31, 2019. JCR/JCI reserves the right to change the content of the information as appropriate.