

# The **Multidisciplinary** aspects of JCI accreditation

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# Outline

- Concept of Multidisciplinary Approach
- Examples of selected JCI standards that require multidisciplinary involvement
- How applying/ implementing multidisciplinary standards /approach resulted in decreasing errors, hospital infections and improved outcome

# The Concept

- “Two heads are better than one”
- Meaning: Two people may be able to solve a problem that an individual cannot

OR

Prevent an Error or Mistake

- Who said it first ?

# Origin of the saying

- **Google:**
- This proverb is first recorded in John Heywood's *A dialogue conteinyng the nomber in effect of all the prouerbes in the Englishe tongue*, 1546: He says:
  - “Some heades haue taken two headis better then one:  
“But ten heads without wit, I wene as good none.”

# Joint Commission International

- Many JCI standards are multidisciplinary and **indicate / imply** the need to use two or more heads to decrease or prevent errors
- These multidisciplinary standards have one or more of the following KEY words :
  - **Multidisciplinary, Collaboration, Integration**
  - Interdisciplinary, Standardization or**
  - Uniformity**

# Issues will be discussed

- Details of only **eight problem issues** that affect patients and hospitals adversely
- How **implementing** the JCI Standards with the Multidisciplinary approach has led to a decrease in errors and resulted in improved patients safety and outcome.

# Problem 1 :Wrong Patient Identification

Errors from wrong or improper Patient Identification:

- Lab Medicine: 345 adverse events were due to identification errors in specimens during 5 weeks.
- JCI and WHO reported **Patient misidentification** was cited in > 100 individual root cause analyses by the Department of Veterans Affairs (VA) from January 2000 to March 2003

# International Patients Safety Goals

**Standard IPSG.1:** The hospital develops and implements a **process** to improve accuracy of patient identifications **Ⓟ: Two identifiers** (not bed #)

- **Uniform** throughout the hospital by **all** caregivers (physicians, nurses, technicians etc.) before:
  - Treatment: Medication or blood administration, IV lines
  - Diagnostic test: Blood withdrawing, Radiologic studies
  - Performing surgery or procedures



# Problem 2 : Communication failure

- Jan 2016: A malpractice study by a US Company: Controlled Risk Insurance (CRICO) found:
  1. “Communication failure linked to 1744 deaths in five years”
  2. “Communication failures were a factor in 30 percent of the malpractice cases

# International Patients Safety Goals

**Standard IPSG.2:** The hospital develops an approach to improve the effectiveness of verbal and/or telephone **communication** among caregivers ®

- Caregivers: Physicians, nurses, pharmacists etc
- **JCI Approach:** Write down, Read back, and Confirm

# IPSG 2.2

**Standard IPSG.2.2:** The hospital develops and implements a **process** for handover communication.®

- Examples of processes :
  - SBAR, ISBAR,
  - IPASS,

# Results with SBAR Implementation

- Implementation of **SBAR** in 1 hospital was associated with substantial drop in the rates of :
  - adverse events (from 90 to 40 per 1000 patient days) and
  - adverse drug events (from 30 to 18 per 1000 patient days)



<b>I</b>	<b>Illness Severity</b>	<ul style="list-style-type: none"><li>• Stable, “watcher,” unstable</li></ul>
<b>P</b>	<b>Patient Summary</b>	<ul style="list-style-type: none"><li>• Summary statement</li><li>• Events leading up to admission</li><li>• Hospital course</li><li>• Ongoing assessment</li><li>• Plan</li></ul>
<b>A</b>	<b>Action List</b>	<ul style="list-style-type: none"><li>• To do list</li><li>• Time line and ownership</li></ul>
<b>S</b>	<b>Situation Awareness and Contingency Planning</b>	<ul style="list-style-type: none"><li>• Know what’s going on</li><li>• Plan for what might happen</li></ul>
<b>S</b>	<b>Synthesis by Receiver</b>	<ul style="list-style-type: none"><li>• Receiver summarizes what was heard</li><li>• Asks questions</li><li>• Restates key action/to do items</li></ul>

# The I-PASS Handoff

- Changes in Medical Errors After Implementation of a Handoff Program “I-PASS”
- *N Engl J Med.* Nov. **2014**; 371:1803-1812
- Outcomes included a 23% decrease in medical errors, a 30% decrease in preventable adverse events, and improved staff communication, all without negatively affecting workflow.

# Problem 3 : Surgical Errors

- JC Sentinel Events Database: wrong site or wrong patient: **over 90 reported in 2007 in US**
- Mody & al (US): 50% of 415 orthopedic surgeons acknowledged having operated on the wrong level at least once
- Michaels & al (CA) 7% of all lawsuit settlements in Canada for wrong site surgery

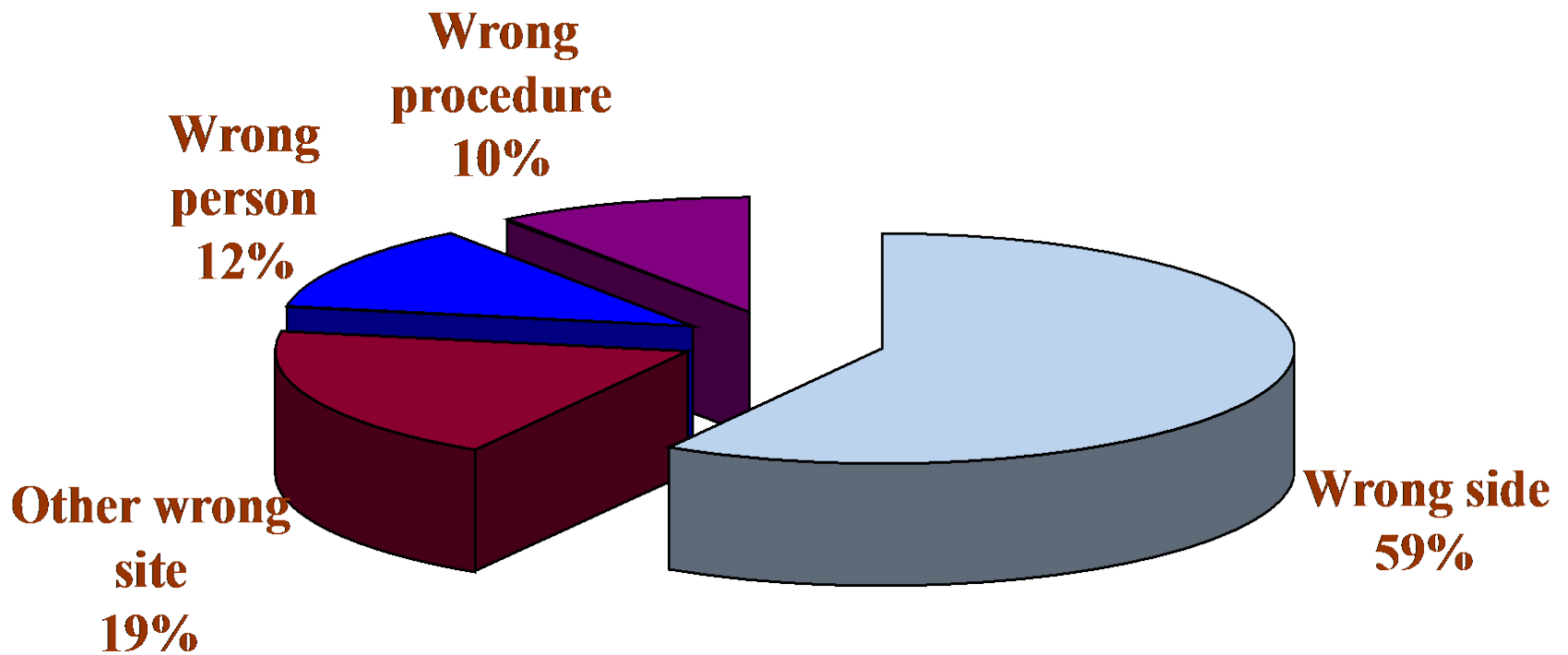
# January 2016

## Johns Hopkins University reported

- **Surgical errors** occur > 4,000 times/year in the U.S.
- Surgeons perform **wrong surgery** or on **the wrong body part** around 20 times a week.
- 9,744 malpractice claims paid \$1.3 billion (in 20 yrs)
  - 6.6% died,
  - 32.9% were permanently injured
  - 59.2% were temporarily injured.



# Types of Errors



# Goal 4: Ensure Correct-Site, Correct-Procedure, Correct-Patient Surgery

- Standard IPSG.4:** The hospital develops an **approach** to ensuring correct-site, correct-procedure, and correct-patient surgery.®
- The approach requires three **Multidisciplinary steps:**
    - 1) **Verification** at multiple locations
    - 2) **Skin marking** with patient /family input
    - 3) A final multidisciplinary step called “Time-out”

# JCI Multidisciplinary TIME-OUT

## Immediately before starting the procedure

- Involve entire team using active communication
- *Surgeon, Anesthesiologist and Nursing staff*
- Must include, at a minimum, and agree on:
  - *Correct patient identity*
  - *Correct procedure*
  - *Correct site / side*
- Anyone who has doubt has right to stop the process
- Must be documented

# ME.1; IPSG.4.1



- All activity stop
- The **full surgical team** conducts and documents a **time-out** procedure in the area in which surgery/ invasive procedure will be performed, just before starting a surgical/invasive procedure.

# Problem 4: Hospital associated infections (HAI)

- CDC reported that in 2011, there were :
  - 722,000 HAIs in U.S. acute care hospitals
  - 75,000 patients with HAIs died during their hospitalizations
- **Three** JCI standards :

# Solution : Hand Hygiene

**Standard IPSG.5** : The hospital **adopts** and **implements** evidence-based hand-hygiene **guidelines** to reduce the risk of health care–associated infections.®

# Prevention and Control of Infection

**Standard PCI.2.** There is a designated coordination mechanism for all infection prevention and control activities that involves physicians, nurses, and others based on the size and complexity of the hospital.

- Program is **coordinated** throughout the organization



# PCI: Education

**Standard PCI.11.** The hospital provides education on infection prevention and control practices to staff, physicians, patients, families, and other caregivers when indicated by their involvement in care.®

- Details: Uniform education for hand hygiene



# Data from hand hygiene education

- Reported by JCI: from the Memorial Hermann Health System (MHHS)
- Using a JCI multidisciplinary tool “**Targeted Solutions Tool**®” improved hand hygiene compliance and was associated with a decrease in health care–associated infections

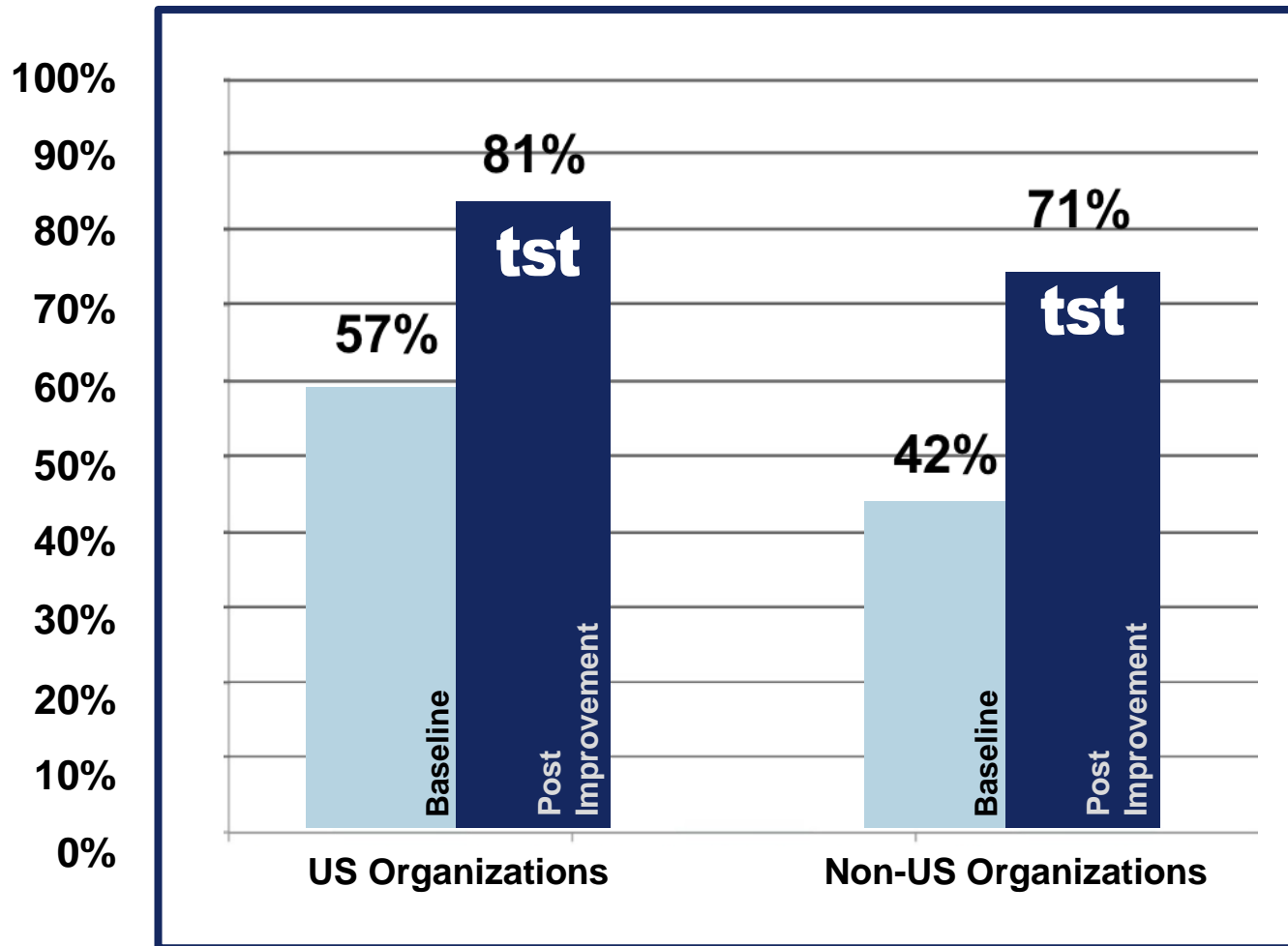
# Jan. 2016 Vol. 42 # 1, The Joint Commission Journal on Quality and Patient Safety

- Based on 31,600 observations, (Oct 2010-Dec 2014)
- MHHS's system-wide hand hygiene compliance study:
  - Baseline compliance rate averaged 58.1%.
  - During the “improve” phase averaged 84.4%,
  - During first 13 months follow up phase 94.7%
  - During the final 12 months compliance was 95.6%
  - (  $p < 0.0001$  for all comparisons to baseline).

# The Joint Commission Journal on Quality and Patient Safety

- **Conclusion:** compliance with the hand hygiene **multidisciplinary “TST” approach** resulted in a decrease in HAI and improving patients safety:
- Adult ICU
  - CLABSI decreased by 49% ( $p = 0.024$ )
  - VAP rates decreased and 45% ( $p = 0.045$ )

# With TST<sup>®</sup>, Hand Hygiene Improves Significantly



# Problem 5 : Conflicting information /Patient education instruction

- Evidence shows that more than one-fifth (20%) of patients hospitalized in the United States reported hospital system problems, including staff providing **conflicting information** and staff not knowing which physician is in charge of their care.<sup>[18](#)</sup>
- **Three** standards for that:

# Access to Care and Continuity of Care

**Standard ACC.3:** The hospital designs and carries out processes to provide **continuity** of patient care services in the hospital and **coordination** among health care practitioners.<sup>Ⓟ</sup>

- **Physicians, nursing & others coordinate their**

# Care of Patients

**Standard COP. 2** : There is a process to integrate and to coordinate care provided to each patient

- Care planning and Care delivery are **integrated** and **coordinated** among settings, departments, and services.
- Collaborative discussions are documented in the patient's record.

# Patient & family Education

## **Standard PFE.4** Health professionals

caring for the patient collaborate to provide education.

- Professionals: Nursing, Medical, Dietary, pharmacy, PT/ OT and social services, etc
- Example: Using one common location to document the multidisciplinary collaboration of education



# Problem 6 : Sedation Deaths

- 2011: Dental sedation accounting for at least 31 child deaths over the past 15 years,
- (Patient) drugged to death, in a Dallas dental chair : Published December 9, 2015
- Joan Rivers died from cardiac arrest while under Sedation for endoscopy Joan Rivers' death was caused by doctors not following proper procedure before sedating her with huge dosage of propofol!

# Anesthesia and surgical Care

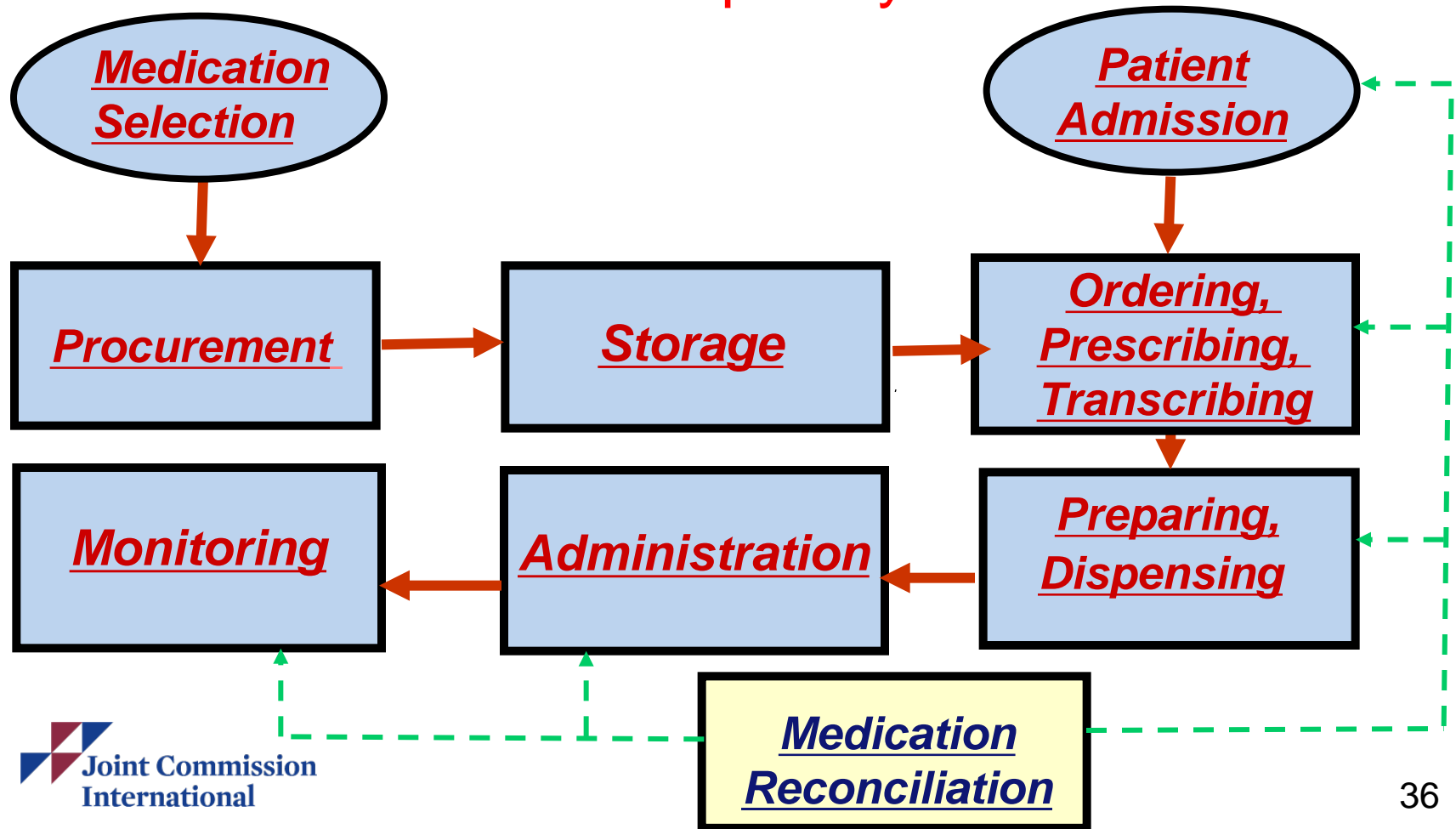
- **Standard ASC.2 ME.1:** Sedation and anesthesia services are **uniform** throughout the hospital.
- **Standard ASC.3** The administration of procedural sedation is **standardized throughout** the hospital.®
  - Special qualification for **ALL** staff giving sedation
  - Available specialized technology for monitoring
  - Obtain informed consent
- Advanced life support available

# Problem 7 : Medication Errors

- Iatrogenic mortality (death caused by medical care or treatment) is now considered the **third leading** cause of death in the United States.
- The **majority** of these errors were **medication related** and occurred in the hospital setting, harming 1.5 million.

# Medication Management Process

Multidisciplinary



# Medication Management and Use

**Standard MMU.5.1** Medication prescriptions or orders are reviewed for appropriateness.

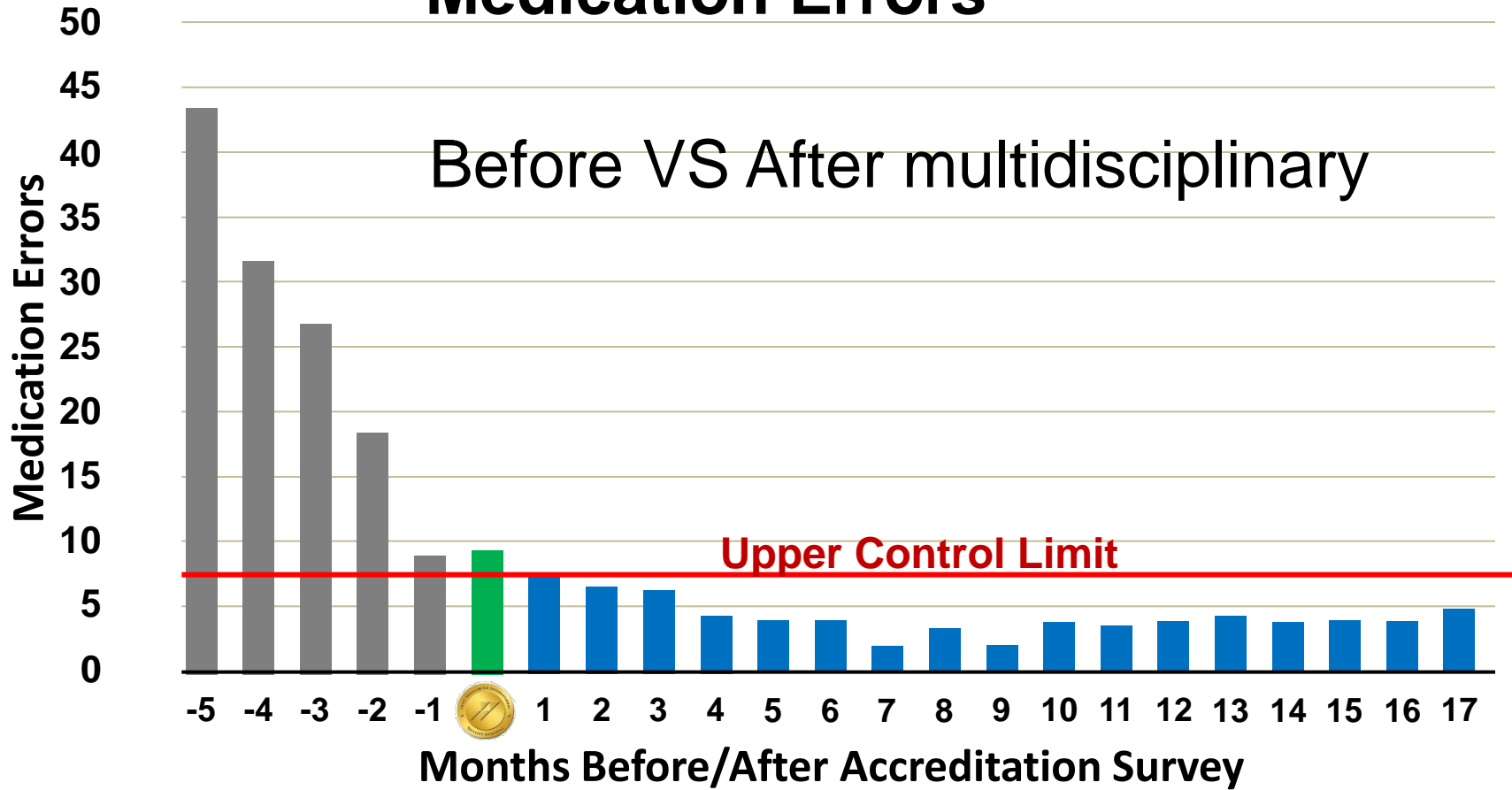
- Including a) to g) **Ⓟ**

- a. Dose, frequency, route,
- b. Therapeutic duplication
- c. Allergy or sensitivity
- d. Drug–drug interaction or food drug interaction
- e. Weight or other physiologic information
- f. Etc,

# Safety: Medication Errors in an Indian Hospital



## Medication Errors



# Problem 8 : Variation in practice and outcomes

- Inappropriate variation in clinical practice occurs when non-evidence-based care is provided and..... is a known cause of poor quality and outcomes. (By John Haughom, MD)
- Example : **Variations in Management** of acute ST segment elevation myocardial infarction (STEMI)

# Uniformity of Practice: Evidence based

- **Standard GLD.11.2** Department/service leaders select and implement **clinical practice guidelines**, and related clinical pathways, and/or clinical **protocols**, to guide clinical care.®
- Department/service leaders **collectively** determine **at least five hospital-wide priority areas** on which to focus.



# One priority evidence

- **Conclusion:** The evidence showed better outcome for treating acute coronary syndromes (MI) depended on having guideline for reducing **door-to-balloon** time for percutaneous coronary intervention

(Cont'd)

# Data to prove it

- Significant decrease in death or re-infarction were observed in hospitals that facilitated primary percutaneous coronary intervention for ST-elevation MI patients to 8.9% versus 19.5%,  $P < 0.001$ ; (through the use of Guidelines / pathways)

# General Conclusion

- When hospitals use the **multidisciplinary** approach, as guided by the JCI standards and supported by the literature, where by there is involvement by the leadership, medical staff, nursing staff and other staff, there will be a decrease in medical errors, and decrease in hospital associated infections resulting in safer hospital stay and better outcome

# The First Certificate

## The Joint Commission Awards First Integrated Care Certification

*Parrish Medical Center Dedicated to Improving  
Outcomes through Integration, Coordination of Care*

**(OAKBROOK TERRACE, Illinois – January 25, 2016)** The Joint Commission's Hospital Accreditation Program announced today that Parrish Medical Center, a public, not-for-profit facility in Titusville, Florida, is the first hospital in the United States to be awarded Integrated Care Certification.



# Thank you!