Early indications are that the South Carolina Safe Care Commitment project, though still in its infancy, holds promise for increasing the reliability of healthcare in that state (cover story). Certainly the progress made thus far supports the framework put forth by the Joint Commission in 2013 to help all healthcare organizations become high reliability organizations.

Using lessons learned from industries outside healthcare—notably, aviation and nuclear power—researchers came up with 3 major changes that healthcare organizations should strive to adopt: leadership commitment to zero patient harm, an overall culture of safety, and widespread process improvements.

Zero patient harm may sound like a laudable yet impossible goal. But patient safety and process improvements are topics addressed in virtually every issue of OR Manager, and often the underlying theme is how different organizations have managed to change not only practices but also mindsets. Creating a just culture seems to be a key step toward eliminating errors.

According to The Joint Commission’s report, “High-Reliability Health Care: Getting There from Here,” a pervasive safety problem is hospital staffs’ failure to report unsafe conditions, behaviors, and practices. Subtle intimidation such as unreturned phone calls or pages can lead to critical miscommunication. Alarm “fatigue” has led to numerous adverse events and heads the ECRI Institute’s Top 10 Health Technology Hazards list for 2014. And, the report says, an estimated 99,000 Americans die in hospitals each year from healthcare-associated infections while hand hygiene compliance hits only the 40% mark.

How can some of these issues be addressed? The report’s authors say it’s important to pinpoint causes of safety failures and measure those that are the most prevalent in a given area of the hospital. They call this approach Robust Process Improvement, or RPI. Participants in the Joint Commission’s Center for Transforming Healthcare projects have gotten results with RPI that include a reduction in colorectal surgical site infections at 7 hospitals from 15.8% to 10.7%; a drop in ineffective handoffs at 10 hospitals from 41% to 18%; and an increase in hand hygiene compliance from 47.5% to 81% at 8 hospitals.

“Hospitals that move toward high reliability establish codes of behavior that are modeled by leaders (including nurses and physicians) who champion efforts to eliminate intimidation and encourage and reward the reporting of blameless errors and unsafe conditions,” the authors say. Being willing to recognize and report close calls and unsafe conditions, they note, is key to fixing problems before patients are put at risk.

It will take time and effort for healthcare organizations to incorporate high reliability concepts into their workflow, and changing the culture is an ongoing challenge. South Carolina is off to a good start, and so is Cincinnati Children’s Hospital Medical Center, which is working to eliminate serious patient harm by 2015.

It’s a new year. Maybe 2014 is the time for your hospital to launch its own high reliability goals.

—Elizabeth Wood

Reference