HCAC2019
5th QUALITY HEALTH CARE
CONFERENCE & EXHIBITION
11 - 13 November 2019

Policy and Practice: A Partnership for Better Outcomes

"Accreditation and Patient Safety Right From the Beginning!"

More Than 100 Years of Accreditation: What's Worked and What's Next

Paula Wilson, CEO

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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.

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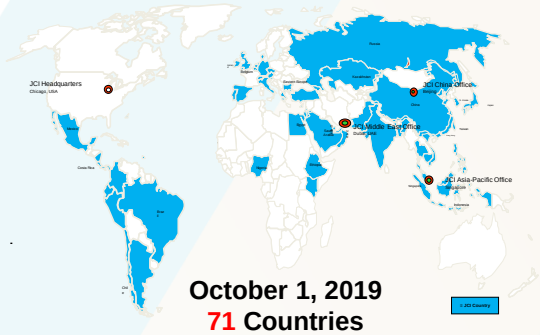
JCI Accreditation Global Footprint



October 1, 2019
71 Countries
1011 Accredited Organizations

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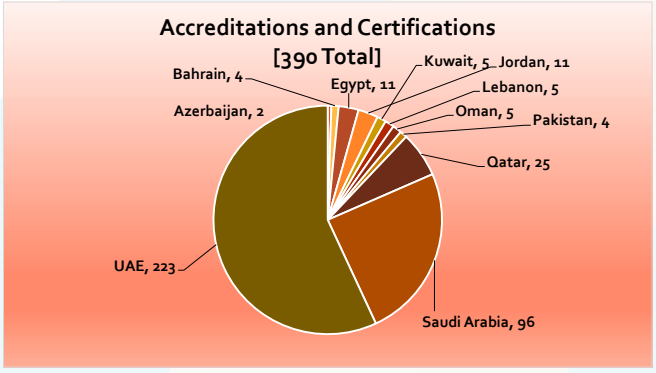
Middle East – October 1, 2019



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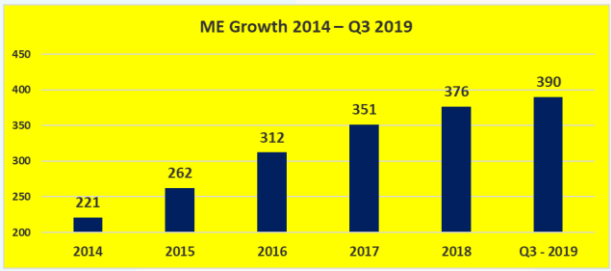
Middle East Accreditation/Certification Program Growth – October 1, 2019



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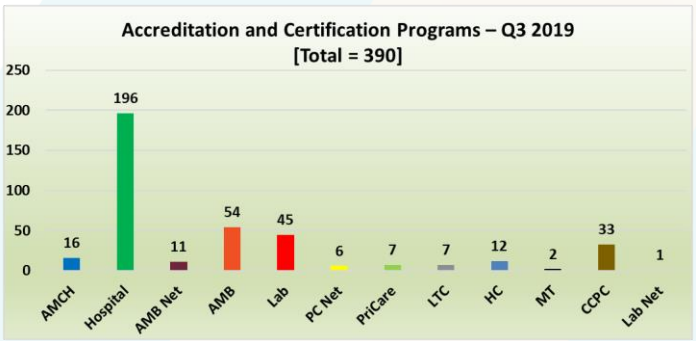
JCI Accreditations/Certification – Middle East



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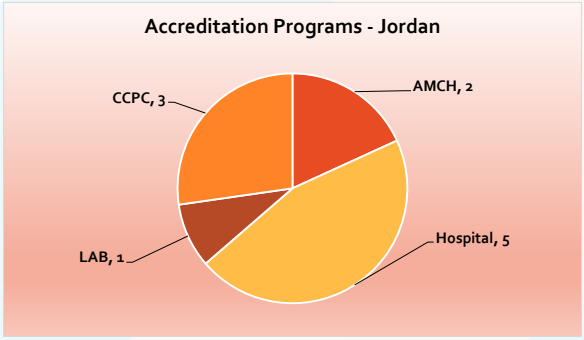
JCI Accreditations by Program – Jordan



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Let's look back about 170 years…

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VIENNA, 1846

- Ignaz Semmelweis OB, Maternity Clinic Vienna – discovered hand washing reduces "childbed fever"

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Istanbul, 1854

- Florence Nightingale: Crimean War, Barrack Hospital, Istanbul;
  - Hand washing, sanitize surgical tools, change linen
  - Mortality went from 60% to 1%

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Medical Education

- American Medical Association established in 1847
  - Tougher standards for medical education
- Abraham Flexner – 1910 The Flexner Report:
  - Dramatic changes to medical education in the U.S. and Canada

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Ernest Codman

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The First Hospital Standards

- 1910 - Dr. Ernest Codman, creates the "End Result System of Hospitalization Standardization", a 3 Step Approach:
  1. Determine if it is a patient, hospital system or physician problem
  2. Quantify the quality issue
  3. Determine a means to prevent in the future

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American College of Surgeons

- 1912: American College of Surgeons formed
- 1917: American College of Surgeons develops a set of minimum standards for hospitals based on the work of Codman
- 1918: American College of Surgeons uses standards to inspect 692 hospitals, only 89 passed the inspection
- They burned the report!
- 1950: 3,200 hospitals approved

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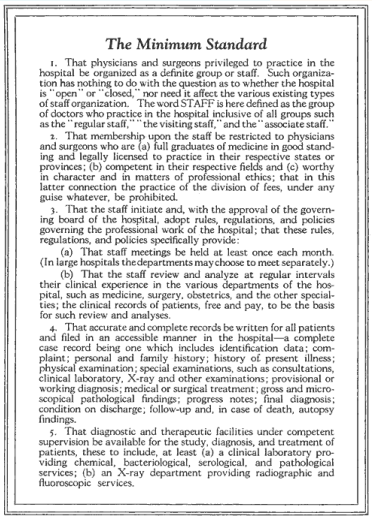

The Minimum Standard

1. That physicians and surgeons privileged to practice in the hospital be organized as a definite group or staff. Such organization has nothing to do with the question as to whether the hospital is "open" or "closed," nor need it affect the various existing types of staff organization. The word STAFF is here defined as the group of doctors who practice in the hospital inclusive of all groups such as the "regular staff," "the visiting staff," and the "associate staff."

2. That membership upon the staff be restricted to physicians and surgeons who are (a) full graduates of medicine in good standing and legally licensed to practice in their respective states or provinces; (b) competent in their respective fields and (c) worthy in character and in matters of professional ethics; that in this latter connection the practice of the division of fees, under any guise whatever, be prohibited.

3. That the staff initiate and, with the approval of the governing board of the hospital, adopt rules, regulations, and policies governing the professional work of the hospital; that these rules, regulations, and policies specifically provide:

(a) That staff meetings be held at least once each month. (In large hospitals the departments may choose to meet separately.)

(b) That the staff review and analyze at regular intervals their clinical experience in the various departments of the hospital, such as medicine, surgery, obstetrics, and the other specialties; the clinical records of patients, free and pay, to be the basis for such review and analyses.

4. That accurate and complete records be written for all patients and filed in an accessible manner in the hospital—a complete case record being one which includes identification data; complaint; personal and family history; history of present illness; physical examination; special examinations, such as consultations, clinical laboratory, X-ray and other examinations; provisional or working diagnosis; medical or surgical treatment; gross and microscopical pathological findings; progress notes; final diagnosis; condition on discharge; follow-up and, in case of death, autopsy findings.

5. That diagnostic and therapeutic facilities under competent supervision be available for the study, diagnosis, and treatment of patients, these to include, at least (a) a clinical laboratory providing chemical, bacteriological, serological, and pathological services; (b) an X-ray department providing radiographic and fluoroscopic services.

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Joint Commission of Hospitals (JCAH)

- 1951 JCAH is formed with "corporate members"
- American College of Surgeons, American College of Physicians, American Hospital Association, American Medical and he Canadian Medical Association Association, were the founding corporate members to create JCAH
- 1959: The Canadians depart
- 1979: American Dental Association was added

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Avedis Donabedian

- 1966: *Evaluating the Quality of Medical Care*
  - Structure: who provides care and where
  - Process: how is the care provided
  - Outcomes: what is the impact of the care
- All three elements required for quality
- Major impact on the Joint Commission's standards

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Lucien Leape Influence

- 1991: NEJM article highlights that adverse events occur in nearly 4% of hospitalizations, with 14% being fatal –
  - or as many people dying if 3 jumbo jets crashed every 2 days
- 1994: JAMA article looks at systems based approach to addressing errors in medicine

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Joint Commission History

- 1994: Joint Commission International is formed
- 1996: Sentinel Event Policy is established in response to 1991 *New England Journal of Medicine* article on adverse events

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Joint Commission History

- 1999: Institute of Medicine releases *To Err is Human*, which details number and severity of medical errors in hospitals – report places spotlight on patient safety
- 1999: First JCI hospital accredited – Albert Einstein Hospital, San Paulo, Brazil
- 2003: Joint Commission launches first National Patient Safety Goals

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Joint Commission History

- 2004: The Joint Commission introduces the Tracer Methodology
- 2006: US Joint Commission begins conducting unannounced onsite surveys

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Accreditation Helps

- Strengthens patient safety efforts
- Comprehensive risk management method
- External unbiased review
- Enhances accountability to the public

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Challenges Remain

- 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

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Looking Forward

- The Center for Transforming Health at the Joint Commission:
  - Learning from highly reliable organizations
  - Leadership, safety culture, improvement

Getting to Zero Harm

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This presentation is current as of November 12, 2019. JCR/JCI reserves the right to change the content of the information as appropriate.

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