Guest Editorial

Relections on Quality and Patient Safety at 2015: Progress and Opportunities

It is a great privilege for me to share my personal and professional reflections on the current efforts to improve the quality and safety of patient care across borders. After completing my position as Director of Clinical Quality Improvement at an 800-bed tertiary care hospital affiliated with Harvard Medical School, in 2002, I was afforded the opportunity to collaborate with some Indian hospitals for designing quality management standards into their operating plan. The application of these principles was relatively new to health care at that time, although other industries had shown that this methodology reduced product defects, increased production efficiencies, and supported employee teamwork for meeting established standards.

My collaboration with these tertiary care hospitals within India continued in parallel with efforts to apply quality management techniques in US hospitals. Avedis Donabedian's "structure–process–outcome" model for quality served as our management framework: "structures" as the settings and administrative systems in which care takes place; "processes" as the components of care delivered; and "outcomes" as recovery and improved functional status.

The early efforts with these Indian hospitals proved to be successful, based on several outcomes. I became a part of their management structures and found support from senior leadership and clinical leaders to provide education and training for such innovations. I worked intensively with these hospitals for more than 5 years, developing standardization of patient care protocols, guidelines, and outcome measures for each department. I learned and was inspired by their willingness and excitement to adopt and emphasize new management goals and clinical operational tools:

- Patient care was now the focus and the common purpose of everyone
- The senior leaders and department directors showed high integrity, setting clear expectations based on values and metrics
- Projects had a clear agenda and expected outcomes based upon shared ideas and vision
- Each team member provided value
- Within two years, the staff was trained in the both the model and integration of quality improvement in their daily work
- Failures and vulnerabilities were met with sensitivity and constructive criticism
- Process and outcome measures were specifically defined and measured quarterly

These hospitals achieved the first of Joint Commission International (JCI) accreditations in India, marking what I viewed as the beginning stages of a quality and patient safety movement in India. Professionally and personally, I felt great satisfaction that I was a part of this achievement.

Since then, over 28 Indian hospitals have received JCI accreditation. In 2006, the National Accreditation Board for Hospital and Health care Providers (NABH) was established. Equivalent to the JCI standards approach, the NABH has accredited >400 Indian hospitals. Accreditation has become a recognized "baseline" for an organization's commitment to the quality and safety of patient care, based on the Donabedian model.

Our Common Imperatives

These early experiences inspired me to build additional partnerships and to share US and international innovations for improvement. Our common imperatives remain important to these efforts today.

While the organization of medicine is culturally different across borders, the needs of our patients remain the same: They get diseases, they worry, and they hope to be cured or relieved of their suffering, and return to work. Patients also want safe and competent care. We organize our health care organizations around care at the bedside, implementing processes that prevent infections, provide the available and appropriate medications, communicate with patients and families, and hopefully increase the likelihood of desired health outcomes based on available professional knowledge and experience.

Practicing medicine is the most intimate of professions. It remains so wherever conducted. Patients expect that they will be treated with dignity, compassion, and the best available standards of care, with the best expected

outcomes. While the quality of hospital care is important in its own right, we try our best to meet the varied needs of patients with whatever resources we have. Our work begins with love and vision: Love of our patients, and love of our work.

International awareness of our common imperatives is reflected by efforts to employ proven strategies that bring patients into closer focus, rather than the sole focus for maximizing revenues. None of this is easy for us, but we push onward – a journey marked by those who embrace change, seek clinical and technical innovations, and hospital leaders who support and encourage these goals in practice.

To Err is Human

The year 2015 marks the 15th anniversary of two landmark reports in the United States: To Err Is Human: Building a Safer Health System and Crossing the Quality Chasm. The history of the US health care quality movement can be divided by the periods before and after these reports. The conventional wisdom was that the quality of care in our hospitals was generally good. Passing the Joint Commission survey constituted a sufficient measure. While the autonomy of physicians to do what they judged best for patients was usually invoked as the "first principle" of good quality of care, these reports indicated otherwise: Medical errors occurred in 4% of hospitalizations and 27% of those events were preventable, including postsurgical infections due to lack of cleanliness, hospital-acquired infections due to inadequate hygiene practices, and errors in medication management. Errors in US hospitals appeared more common than what was believed, precipitating a major public health concern regarding these gaps in patient safety. Although Joint Commission accreditation remains mandatory for a hospital to operate in the United States, it was clearly not sufficient in fully addressing patient safety.

Since then, with the proliferation of research and proven techniques to improve quality and safety, the international public health community actively supports global efforts and collaborations. The World Health Organization (WHO) provides guidelines, checklists, tools to reduce medication errors, and other materials for global improvement; the Institute for Health Care Improvement provides working papers, online training, and tools/technique, such as trigger tools for identifying potential harm; the International Monetary Fund has a public health initiative to better understand the needs and experiences of patient care; and the Organization of Economic Cooperation and Development recently issued a multicountry study on global patient safety data. Country-specific studies and strategies are published in peer-reviewed patient safety journals. We continue to learn better ways to get better, and we learn through cross-border collaborations.

Getting Better at Getting Better: What We have Learned

With the 2006 deployment of the NABH accreditation standards, Indian hospitals have joined the journey for improving quality and safety. Our common imperatives seek to "do no harm" and to do all what we can to ensure that a proposed treatment's benefit outweighs the risks inherent in its implementation.

We have learned that preventing infections must include handwashing before and after contact with patients and that hand hygiene must be a global standard. Protocols and guidelines are available to train all staff to monitor adherence. There are new safety protocols across almost every area of a hospital to reduce health care-associated infections, surgical complications, staff "handoff" communications, medication errors, and Intensive Care Unit safety. We've learned from other industries, like aviation, that implementing checklists improves patient safety by standardizing practices by adhering to protocols pre- and postsurgical procedures. Surgical checklists have been proven to reduce complications, length of stay, readmissions, and mortality. The WHO checklist has been tested at several hospitals around the world with the following results: Complications after surgery were reduced by more than one-third, and death rates fell by almost half. By 2012 more than 2000 hospitals had implemented checklists, including procedures for central-line insertion, anesthesia, mechanical ventilation, and childbirth. However, the implementation of checklists is not so simple, says Atul Guwande. Studies have shown that too often they are not completed or not always used, required team members were not present all the time, and not all items on the checklist were read aloud. Guwande has found that it is critical for leaders to take time to explain why and how to use checklists. These documents can be modified to fit into the local workflow – such personalization creates a feeling of "pride of ownership" that encourages their utilization. .

Quality and safety is the work of leadership, of clinical staff, and of hospital systems. Devoting human and financial resources in these efforts will reduce repeat testing, readmissions, longer hospital stays, and most importantly improve outcomes for the "high-risk" patient suffering from multiple comorbidities.

Advancing Global Quality and Patient Beyond 2015

With limited resources, we must continue to collaborate globally to incorporate, locally, what we've learned about quality and safety:

- Quality and safety must be a primary responsibility for our health care systems
- The cost to patients, health care systems, and societies not implementing these principles is considerable
- Increasing investment in improvement and prevention, given its successful "track record" is justified
- Local programs, training, and defined interventions must be in place
- Active engagement of staff and patients is critical
- National policies should support these improvement efforts

Going forward, we must together focus on measuring and learning from both what can go wrong and from what goes right in patient care; know that humans are prone to error; measure errors and learn to manage these risks; invest resources that will standardize and simplify complex processes; measure what goes right and teach effectiveness and reliability; and, most importantly, build and invest in our knowledge building (Office of Economic Co-operation and Development, Paris, 2017).

We must be willing to measure care and define outcomes of our patients. Culture matters and local needs will help in such definitions. From the global perspective, we seek to better understand patient outcomes in order to better manage costs and provide value-based care. We want to know how they survive their illnesses and manage their disabilities, how often they suffer from complications and additional comorbidities, and if and how they are able to return to work. These efforts will represent the next decade of quality improvement.

"The highest education is that which does not merely give us information but makes our life in harmony with all existence."

—R. Tagore

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