Vaccines Alone Won't Solve the Problem of Healthcare Worker Safety

Don Berwick, IHI president emeritus and senior fellow, has characterized our current healthcare system as "repair shops" where we rise to the challenge of fixing and correcting the damage for what's broken. Often work gets accomplished without deeply understanding and addressing the underlying causes and determinants of the problem.

Do You Need to Know Six Sigma?

We've all heard of Six Sigma. It's familiar terminology to any healthcare leader focused on quality improvement. Surely, however, there are some of you out there who know only that it is a methodological tool used to recognize variability, prevent error and manage change. How, exactly, does it work? Will understanding it better help you to do a better job? No doubt.

Six Sigma is essential knowledge for any healthcare leader seeking to guide his or her organization toward error-free operation for zero patient harm. This methodological approach to recognizing and reducing error is viewed by some as a

framework supporting the high-reliability organization. When Chassin and Loeb first recommended in 2013 that healthcare strive for high reliability, Six Sigma was one of the three process-improvement tools they recommended—along with Lean and Change Management.

Fortunately, ACHE members and nonmembers alike can learn more about Six Sigma in the second edition of *High-Reliability Healthcare: Improving Patient Safety and Outcomes with Six Sigma* by Robert Barry, PhD; Amy C. Smith, DNP, RN, FACHE; and Clifford E. Brubaker, PhD. As the authors point out in a chapter entitled "Why Six Sigma?", some healthcare executives don't need to review this volume. If you lead an organization that "provides error-free care to your patients, your patients are discharged on schedule every time, every patient leaves with a correct financial statement and the proper instructions for at-home care…. Your facility has happy and loyal clientele, your staff has professional satisfaction, and your managers and resources are applied to positive purposes," then you, most certainly, do not need this book.

If that description doesn't quite fit you yet, you may want to pick up this reader-friendly text written with the practical needs of the healthcare executive in mind. The book explores and explains how the Six Sigma approach can improve an organization's output by reducing variability and error, solving problems, managing change and monitoring progress quantitatively. Six Sigma can be put to work to improve your patient outcomes and deliverables, reduce waste, augment profits and boost employee morale.

One of the keys of Six Sigma is poka-yoke (pronounced po' kah yo' kay), which translates from Japanese to "prevention of error by inadvertent action." The three rules of poka-yoke

are:

1. Make it easier for the person to do the right thing than the wrong thing.
2. Make mistakes obvious to the person immediately.
3. Allow the person to take corrective action on the spot.

Six Sigma applies poka-yoke guidelines to task design, provides systematic problem-detection and solving methodologies, and offers a quantitative way to manage change—making it especially applicable to healthcare and the goal to eliminate preventable harm. Six Sigma derives its name from the goal of achieving no more than 3.4 errors per million opportunities. In an industry in which errors can easily mean significant patient or employee injury or worse, Six Sigma is an essential instrument for the healthcare leader's toolkit.

Engaging Patients in Improving Diagnostic Quality

Inaccurate or delayed diagnoses are the most common, most catastrophic and most costly of serious medical errors. The National Academy of Medicine believes "improving the diagnostic process is not only possible, but also represents a moral, professional and public health imperative."

Safer Together: A National Effort

As leaders, we represent more than the roles we play. We belong to a profession centered on an important calling: to care for those who put their trust in us and to model the values for which we stand. We work tirelessly to advance health for our patients and communities, and each day we recommit to the safety imperative. We've worked together through initiatives and innovations to reduce preventable harm in our institutions. Even as we celebrate these achievements, we recognize that continual assessment and improvement are key to making further inroads.

Diagnostic Errors in the Emergency Department: A Systematic Review

The National Academy of Medicine (NAM) has called diagnostic error a "blind spot" for modern medicine and improving diagnosis a "moral, professional, and public health imperative."[1] The emergency department (ED) is a known high-risk site for diagnostic error.[2–7] **The key decisional dilemma for this evidence review is "What are the most common and**

significant medical diagnostic errors in the ED, and why do they happen?" The goal is to determine the following: (1) What are the major clinical conditions associated with diagnostic errors and misdiagnosis-related harms in the ED, particularly serious misdiagnosis-related harms (death or permanent disability)?; (2) How common are these diagnostic errors and any associated harms?; (3) What are the key causes for errors and harms, and are there commonalities across clinical conditions?

National Action Plan to Advance Patient Safety: 4 Focus Areas

Improving safety has been a top priority at healthcare organizations across the country for the last two decades, but preventable harm is still an issue. To help tackle this problem, the Institute for Healthcare Improvement-convened National Steering Committee for Patient Safety released *Safer Together: A National Action Plan to Advance Patient Safety* earlier this fall.

Interview: William Gunnar, MD, JD, FACHE, Veterans Affairs National Center for Patient Safety

The recent release of *Safer Together: A National Action Plan to Advance Patient Safety* marks the latest contribution of William Gunnar, MD, JD, FACHE, to a better healthcare system. Dr. Gunnar, director of the U.S. Department of Veterans Affairs (VA) National Center for Patient Safety, also is a member of the National Steering Committee for Patient Safety, which established the National Action Plan's core values.

ACHE, Along With IHI, AHRQ Announce National Action Plan to Advance Patient Safety

The American College of Healthcare Executives today joins with members of the National Steering Committee for Patient Safety to announce the release of a National Action Plan to provide health systems with renewed momentum and clearer direction for eliminating preventable medical harm. Continue Reading→

Safety 101 Syllabus: Establish Organizational Behavior Expectations

The COVID-19 pandemic has led hospitals across the globe to rethink safety and implement new processes and protocols to protect the health of patients, visitors, staff and anyone else who might enter a healthcare organization. Such measures include creating COVID and non-COVID patient care units, building negative pressure rooms, expanding the use of PPE and encouraging more telehealth visits. These solutions have all helped meet the particular challenges of operating during a global pandemic but maintaining a culture of safety only happens when leaders set and model behavioral expectations for the organization as a whole.

Safety 101 Syllabus: Select, Develop and Engage Your Board

When it comes to achieving zero harm in healthcare, there is no silver bullet solution. *Leading a Culture of Safety: A Blueprint for Success* does, however, outline six leadership domains that can help ensure safety remains a focus from the top down in hospitals and other healthcare settings.