

The Joint Commission Journal on Quality and Patient Safety®

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EDITORIALS

- 559** Promoting Action on Diagnostic Safety: The Safer Dx Checklist

P.W. Brady, T.L. Marshall, K.E. Walsh

Diagnostic error research, and hence programmatic efforts to reduce diagnostic errors, has lagged substantially behind other safety research. This delay has multiple contributing factors, but it is crucial that these common errors are rapidly and systematically addressed. In this editorial in response to a study by Singh et al. in this issue of the *Journal*, Brady and colleagues discuss the recent progress in diagnostic quality and safety research and how the Safer Dx Checklist advances the field.

- 561** The Journey to Achieve Health Care Equity: The New Joint Commission Accreditation Standard and Call for Papers

D.W. Baker

Though health care disparities are often viewed through the lens of social injustice, at their most basic level they are a quality of care problem. Like medication errors, health care-acquired infections, and falls, health care disparities must be examined, the root causes understood, and those causes addressed with targeted interventions. Working from the new Joint Commission standard for addressing health care disparities, Baker stresses the need for a new approach to reduce these disparities. As Editor-in-Chief for the *Journal*, he issues this call for papers on work being done to address health-related social needs and health care disparities.

ORIGINAL ARTICLES

Process Improvement

- 564** Variations in Code Team Composition During Different Times of Day and Week and by Level of Hospital Complexity

Y. Li, G.K. Lighthall

Compared to regular weekday hours, survival rates for in-hospital cardiac arrests are lower during nights and weekends in both adult and pediatric patient populations. To address this issue, Li and Lighthall conducted this study to evaluate variations of personnel attending to codes based on day/night/weekend conditions within the US Veteran Affairs system, as well as the variations of personnel responsible for intubations during codes.

Performance Improvement

- 572** Improving Sepsis Management Through the Emergency Quality Network Sepsis Initiative

A. Rodos, E. Aaronson, C. Rothenberg, P. Goyal, D. Sharma, T. Slesinger, J. Schuur, A. Venkatesh

Public reporting of the Centers for Medicare & Medicaid SEP-1 sepsis quality measure is often too late and lacking the data granularity to inform real-time quality improvement. The American College of Emergency Physicians Emergency Quality Network Sepsis Initiative sought to support quality improvement efforts through benchmarking of preliminary draft SEP-1 scores for emergency department patients. Rodos and colleagues performed a cross-sectional analysis to determine the anticipatory value of these preliminary SEP-1 benchmarking scores and publicly reported performance.

Adverse Events

- 581** Developing the Safer Dx Checklist of Ten Safety Recommendations for Health Care Organizations to Address Diagnostic Errors

H. Singh, U. Mushtaq, A. Marinez, U. Shahid, J. Huebner, P. McGaffigan, D.K. Upadhyay

Multiple complex cognitive and system factors make diagnostic errors particularly challenging. To address this problem, Singh and colleagues used a multimethod approach to develop an expert consensus-based checklist of 10 high-priority safety practices HCOs can use to improve the safety of the diagnostic process.

IMPROVEMENT BRIEF

- 591** Mi Plan: Using a Pediatric-Based Community Health Worker Model to Facilitate Obtainment of Contraceptives Among Latino Immigrant Parents with Contraceptive Needs

T.M. Caballero, E. Miramontes-Valdes, S. Polk

Contraceptive health care services and Spanish-language contraceptive information are particularly challenging to access for uninsured immigrants with limited English proficiency. Pediatric settings pose a unique opportunity to address these needs among parents whose children access pediatric care. Caballero and colleagues performed this study to pilot the feasibility of a community health worker to support parental contraceptive needs within a pediatric setting serving a high number of Latino immigrant families.

TOOL TUTORIAL

- 599** An Asset-Based Quality Improvement Tool for Health Care Organizations: Cultivating Organizationwide Quality Improvement and Health Care Professional Engagement

V.A. Loving, C. Nolan, M. Bessel

Health care organizations are often biased toward deficit-based quality and safety improvement techniques, but such techniques may elicit negative sentiments from frontline health care professionals, causing disengagement and adverse event underreporting. In this article, Loving and colleagues describe the development of an organizationwide asset-based quality improvement tool intended to complement deficit-based quality improvement.

RESEARCH LETTER

- 609** An Injury Mitigation Program Highlights the Importance of Adhering to Current Infection Control Policies

E.H. Chen, N. Addo, G. Cohen

Mitigation measures for sharps injuries and body fluid exposures include training on and adhering to standard precautions for procedures, providing feedback mechanisms, and using safety devices. During the SARS-CoV-2 pandemic, a health system instituted universal use of face mask and eye protection for patient care activities to reduce person-to-person viral transmission. Chen and colleagues reviewed incidents reported to Occupational Health Services and hypothesized that fewer incidents, particularly splash incidents, would be reported during the pandemic period and report their findings in this article.

COMMENTARY

- 612** How to Mitigate the Effects of Cognitive Biases During Patient Safety Incident Investigations
J.E. Rogers, T.R. Hilgers, J.R. Keebler, T. Looke, E.H. Lazzara

The effect of biases and heuristics on human cognition and decision-making is fairly well-understood, and some scholars have even applied these principles to understand how biases and heuristics may affect individuals who carry out accident investigations. In this commentary, Rogers and colleagues discuss five cognitive biases that may negatively influence the process and outcomes of patient safety incident investigations and present examples and targeted solutions that may be deployed during patient safety incident investigation team training to prepare multidisciplinary teams to mitigate the effect of biases on their investigations.

- 617** High Primary Cesarean Section Rates: Strategies for Improvement
F.A. Crespo, U. Verma

Compared to a vaginal delivery, cesarean delivery poses greater maternal and neonatal risks. Yet approximately one in three women giving birth in the United States will undergo cesarean delivery. In this commentary, Crespo and Verma provide an update on evidence-based approaches to lowering cesarean rates among low-risk births and discuss the influence of provider and hospital unit culture with a goal of providing recommendations to help lower low-risk cesarean births.

625 INFORMATION FOR AUTHORS
