

# SEEK AND FIND THE PATH TO HIGH RELIABILITY



“The road to high reliability is an ongoing journey.”

–Mark Chassin, MD, FACP, MPP, MPH  
President and CEO of The Joint Commission

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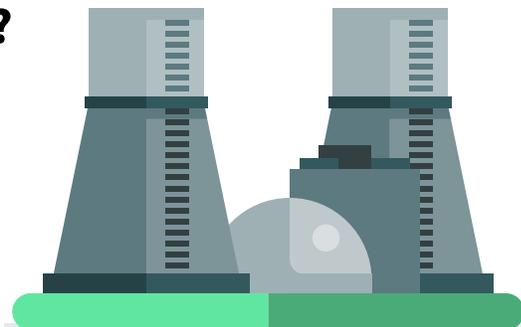
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## WHICH IS SAFER?



### HOSPITAL

In a one-year span, nearly 650,000 patients in the United States acquire a healthcare-related infection as a result of their hospital visit.



### NUCLEAR POWER PLANT

In over 16,000 cumulative reactor-years of commercial operation in 32 countries, there have been only three major accidents at nuclear power plants.

The goal to do no harm may seem lofty considering the state of US healthcare, but it may also be the only way to make significant strides in patient quality and safety. In this Ebook, we will discuss the principles of High Reliability Organizations (HROs) and how they can be used in the healthcare setting. **Let's get started!**

# PRINCIPLES OF HROs | PREVENTION

Based on research by Drs. Karl E Weick and Kathleen M. Sutcliffe, High Reliability Organizations exhibit five behaviors that account for their ability to prevent and contain unexpected catastrophic events. Although the following five principles are challenging, an HRO's obsession with safety and a 100 percent safety goal force the organization to constantly search for new ways to improve.

## HRO PRINCIPLES TO PREVENT ADVERSE EVENTS

1

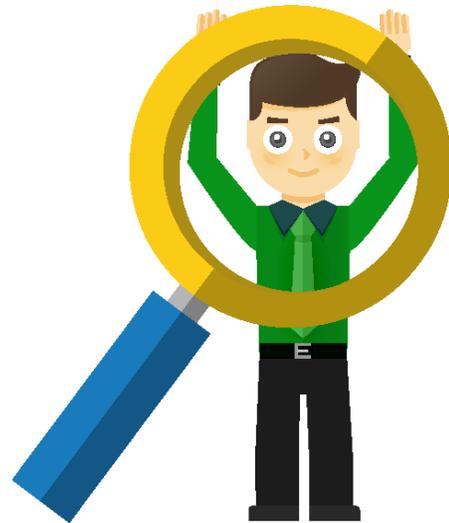
***Preoccupation with failure.*** Everyone in the organization is always on the lookout for potential problems. They look for early signs of failure—mistakes that may occur down the line even though an adverse event has not yet occurred. They count close calls and near misses to be as important as adverse events.

2

***Reluctance to simplify.*** HROs look for complexity in situations, avoid labels and refuse to make assumptions that may interfere with a deeper analysis of a situation. In the case of adverse events, they perform thorough root cause analyses (RCAs) and are not satisfied with simple explanations. They constantly challenge their previously-held beliefs to expand their awareness of potential errors.

3

***Sensitivity to operations.*** HROs are realistic, taking into account what the organization is actually doing instead of what it is supposed to be doing. They don't place blame on any person or single event. Instead, they acknowledge that adverse events are more complicated than a single error at the time of the event, but are a result of other unresolved errors that were previously unidentified elsewhere in the system.



# PRINCIPLES OF HROs | CONTAINMENT

## HRO PRINCIPLES TO CONTAIN ADVERSE EVENTS

4

***Committed to resilience.*** Understanding that adverse events can become more severe if not contained, HROs control and recover quickly from errors. HROs create contingency plans and practice worst-case scenarios so they are able to keep all other processes operating smoothly while fixing the problem at hand.

5

***Defer to expertise.*** HROs realize that expertise doesn't always follow the chain of command. Leadership does not necessarily know more than those working on the front line. HROs believe good leaders welcome input and encourage communication between all levels of the organization in order to manage adverse events.

***“High Reliability Organizing is an ongoing process that is never perfect, complete, or total. [HROs] are committed to safety at the highest level.... and adopt a special approach to its pursuit.” – Dr. Paul Schulman***



# TJC's TAKE ON HROs | LEADERSHIP COMMITMENT

Understanding that hospitals could not be magically transformed from highly unreliable to highly reliable, The Joint Commission (TJC) conducted its own [research](#) using HRO principles to improve safety in hospitals. According to TJC, a healthcare organization's level of maturity varies based on 14 components within three categories: Leadership Commitment, Safety Culture and Robust Process Improvement (RPI). Understanding your organization's performance level in each of these components will help you establish a starting point for your path to high reliability.

## CATEGORY ONE: LEADERSHIP COMMITMENT

<b>COMPONENT</b> ①	<b>BEGINNING</b>	<b>DEVELOPING</b>	<b>ADVANCING</b>	<b>APPROACHING</b>
<b>BOARD</b>	Board's quality focus is nearly exclusively on regulatory compliance.	Full board's involvement in quality is limited to hearing reports from its quality committee.	Full board is engaged in the development of quality goals and approval of a quality plan and regularly reviews adverse events and progress on quality goals.	Board commits to the goal of high reliability (i.e., zero patient harm) for all clinical services.

<b>COMPONENT</b> ②	<b>BEGINNING</b>	<b>DEVELOPING</b>	<b>ADVANCING</b>	<b>APPROACHING</b>
<b>CEO/MANAGEMENT</b>	CEO/management's quality focus is nearly exclusively on regulatory compliance.	CEO acknowledges need for plan to improve quality and delegates the development and implementation of a plan to a subordinate.	CEO leads the development and implementation of a proactive quality agenda.	Management aims for zero patient harm for all vital clinical processes; some demonstrate zero or near-zero rates of harm.

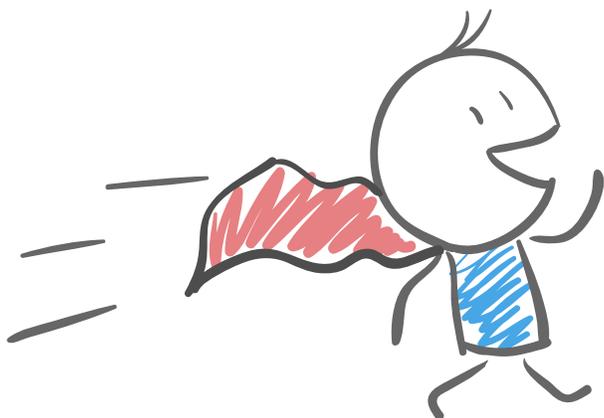
<b>COMPONENT</b> ③	<b>BEGINNING</b>	<b>DEVELOPING</b>	<b>ADVANCING</b>	<b>APPROACHING</b>
<b>PHYSICIANS</b>	Physicians rarely lead quality improvement activities; overall participation by physicians in these activities is low.	Physicians champion some quality improvement activities; physicians participate in these activities in some areas but not widely.	Physicians often lead quality improvement activities; physicians participate in these activities in most areas, but some important gaps remain.	Physicians routinely lead clinical quality improvement activities and accept the leadership of other appropriate clinicians; physicians' participation in these activities is uniform throughout the organization.

# TJC's TAKE ON HROs | LEADERSHIP COMMITMENT

<b>COMPONENT</b> 4	<b>BEGINNING</b>	<b>DEVELOPING</b>	<b>ADVANCING</b>	<b>APPROACHING</b>
<b>QUALITY STRATEGY</b>	Quality is not identified as a central strategic imperative.	Quality is one of many competing strategic priorities.	Quality is one of the organization's top three or four strategic priorities.	Quality is the organization's highest-priority strategic goal.

<b>COMPONENT</b> 5	<b>BEGINNING</b>	<b>DEVELOPING</b>	<b>ADVANCING</b>	<b>APPROACHING</b>
<b>QUALITY MEASURES</b>	Quality measures are not prominently displayed or reported internally or publicly; the only measures used are those required by outside entities and are not part of reward systems.	Few quality measures are reported internally; few or none are reported publicly and are not part of reward systems.	Routine internal reporting of quality measures begins, with the first measures reported publicly and the first quality metrics introduced into staff reward systems.	Key quality measures are routinely displayed internally and reported publicly; reward systems for staff prominently reflect the accomplishment of quality goals.

<b>COMPONENT</b> 6	<b>BEGINNING</b>	<b>DEVELOPING</b>	<b>ADVANCING</b>	<b>APPROACHING</b>
<b>INFORMATION TECHNOLOGY</b>	IT provides little or no support for quality improvement.	IT supports some improvement activities, but principles of safe adoption are not often followed.	IT solutions support many quality initiatives; the organization commits to principles and the practice of safe adoption.	Safely adopted IT solutions are integral to sustaining improved quality.



*Leadership commitment plays an important role in quality improvement. Without a deep commitment by leadership, organization-wide high reliability is impossible. Support your leadership, and encourage them to be the champions of zero harm.*

# TJC's TAKE ON HROs | SAFETY CULTURE

## CATEGORY TWO: SAFETY CULTURE

<b>COMPONENT</b> 7	<b>BEGINNING</b>	<b>DEVELOPING</b>	<b>ADVANCING</b>	<b>APPROACHING</b>
<b>TRUST</b>	Trust or intimidating behavior is not assessed.	First codes of behavior are adopted in some clinical departments.	CEO and clinical leaders establish a trusting environment for all staff by modeling appropriate behaviors and championing efforts to eradicate intimidating behaviors.	High levels of (measured) trust exist in all clinical areas; self-policing of codes of behavior is in place.
<b>COMPONENT</b> 8	<b>BEGINNING</b>	<b>DEVELOPING</b>	<b>ADVANCING</b>	<b>APPROACHING</b>
<b>ACCOUNTABILITY</b>	Emphasis is on blame; discipline is not applied equitably or with transparent standards; no process exists for distinguishing "blameless" from "blameworthy" acts.	The importance of equitable disciplinary procedures is recognized, and some clinical departments adopt these procedures.	Managers at all levels accord high priority to establishing all elements of safety culture; adoption of uniform equitable and transparent disciplinary procedures begins across the organization.	All staff recognize and act on their personal accountability for maintaining a culture of safety; equitable and transparent disciplinary procedures are fully adopted across the organization.
<b>COMPONENT</b> 9	<b>BEGINNING</b>	<b>DEVELOPING</b>	<b>ADVANCING</b>	<b>APPROACHING</b>
<b>IDENTIFYING UNSAFE CONDITIONS</b>	Root cause analysis is limited to adverse events; close calls ("early warnings") are not recognized or evaluated.	Pilot "close call" reporting programs begin in few areas; some examples of early intervention to prevent harm can be found.	Staff in many areas begin to recognize and report unsafe conditions and practices before they harm patients.	Close calls and unsafe conditions are routinely reported, leading to early problem resolution before patients are harmed; results are routinely communicated.

# TJC's TAKE ON HROs | SAFETY CULTURE

COMPONENT <sup>10</sup>	BEGINNING	DEVELOPING	ADVANCING	APPROACHING
STRENGTHENING SYSTEMS	Limited or no efforts exist to assess system defenses against quality failures and to remedy weaknesses.	RCAs begin to identify the same weaknesses in system defenses in many clinical areas, but systematic efforts to strengthen them are lacking.	System weaknesses are cataloged and prioritized for improvement.	System defenses are proactively assessed, and weaknesses are proactively repaired.
COMPONENT <sup>11</sup>	BEGINNING	DEVELOPING	ADVANCING	APPROACHING
ASSESSMENT	No measures of safety culture exist.	Some measures of safety culture are undertaken but are not widespread; little if any attempt is made to strengthen safety culture.	Measures of safety culture are adopted and deployed across the organization; efforts to improve safety culture are beginning.	Safety culture measures are part of the strategic metrics reported to the board; systematic improvement initiatives are under way to achieve a fully functioning safety culture.

***A culture of safety can only be achieved if all staff is given the power and confidence to speak up. Consider revising policies and procedures to require and reward those who report unsafe conditions, close calls and near misses.***



# TJC's TAKE ON HROs | ROBUST PROCESS IMPROVEMENT

## CATEGORY THREE: ROBUST PROCESS IMPROVEMENT

<b>COMPONENT</b> <sup>12</sup>	<b>BEGINNING</b>	<b>DEVELOPING</b>	<b>ADVANCING</b>	<b>APPROACHING</b>
<b>METHODS</b>	Organization has not adopted a formal approach to quality management.	Exploration of modern process improvement tools begins.	Organization commits to adopt the full suite of Robust Process Improvement (RPI) tools.	Adoption of RPI tools is accepted fully throughout the organization.

<b>COMPONENT</b> <sup>13</sup>	<b>BEGINNING</b>	<b>DEVELOPING</b>	<b>ADVANCING</b>	<b>APPROACHING</b>
<b>TRAINING</b>	Training is limited to compliance personnel or to the quality department.	Training in performance improvement tools outside the quality department is recognized as critical to success.	Training of selected staff in RPI is under way, and a plan is in place to broaden training.	Training in RPI is mandatory for all staff, as appropriate to their jobs.

<b>COMPONENT</b> <sup>14</sup>	<b>BEGINNING</b>	<b>DEVELOPING</b>	<b>ADVANCING</b>	<b>APPROACHING</b>
<b>SPREAD</b>	No commitment to widespread adoption of improvement methods exists.	Pilot projects using some new tools are conducted in a few areas.	RPI is used in many areas to improve business processes as well as clinical quality and safety; a positive ROI is achieved.	RPI tools are used throughout the organization for all improvement work; patients are engaged in redesigning care processes, and RPI proficiency is required for career advancement.



*Robust Process Improvement combines improvement methods including lean (to remove waste), six sigma (to reduce negative outcomes) and change management (to help implement and sustain improvements). It's important to realize that there is no single method that is appropriate for all situations.*

# HRO METHODS | HUDDLING

Remember that high reliability is a journey, and no matter where your organization is in its maturity level, there are steps you can take to get on the right path. The following methods can help to advance your organization’s progress toward high reliability.

**Daily huddling to embed collective mindfulness.** Huddling each day not only improves the quality of the information shared, it helps staff with accountability and collaboration, creating a collective mindset on safety. In a huddle, the individuals involved describe situations by looking back (reporting events that have taken place), looking forward (identifying potential risk) and integrating (coming up with a plan). See the chart below for an idea of how huddling could work across an entire organization.

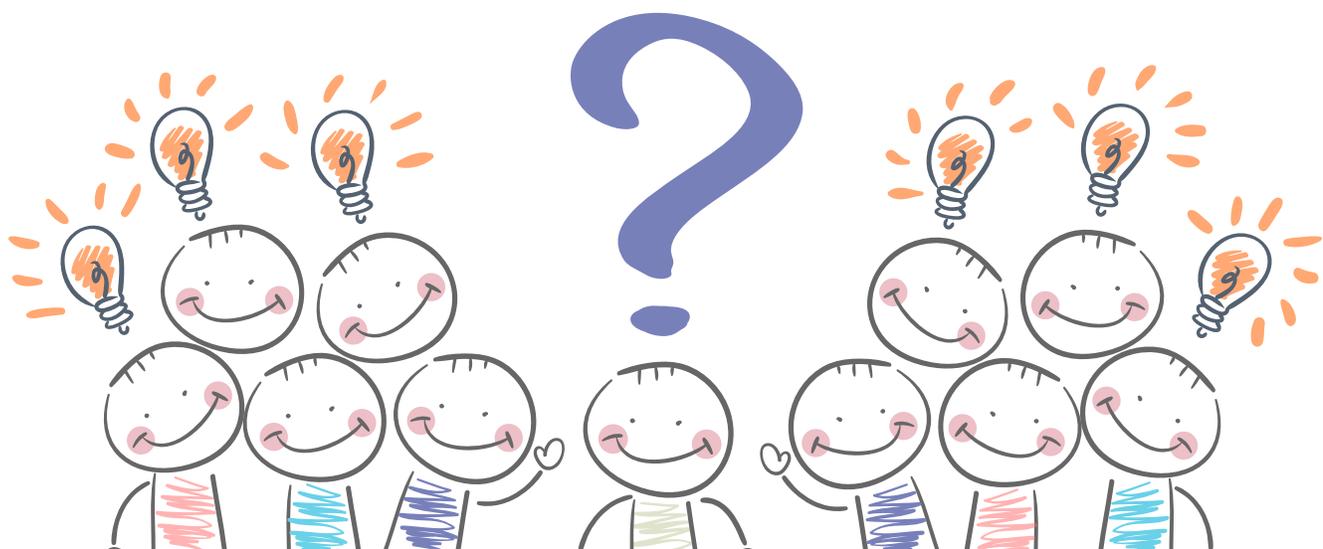
<b>UNIT HUDDLE</b>		
<b>Individual Providers Report (individual units report)</b>		
<i>Look Back</i>	<i>Look Forward</i>	<i>Integration</i>
Individual providers report on unexpected events and medical response team calls.	Individual providers report on individual patients at risk for safety events.	Charge nurse considers overall unit status, planned discharges and staffing needs.
<b>INPATIENT HUDDLE</b>		
<b>Charge Nurses Report (units collectively report)</b>		
<i>Look Back</i>	<i>Look Forward</i>	<i>Integration</i>
Charge nurses from each unit report on unexpected events and transfers to higher levels of care.	Individual units report on higher risk patients in the unit and overall unit status.	Leadership works with charge nurses to develop plans and predictions for highest risk patients, develop capacity plan throughout the system, predict and mitigate experience failures.
<b>DAILY OPERATIONS BRIEF</b>		
<b>Leaders Report (hospital-wide communications)</b>		
<i>Look Back</i>	<i>Look Forward</i>	<i>Integration</i>
Leaders report on unexpected outcomes over last 24 hours and resolve concerns raised at previous brief.	Leaders predict and plan for big issues of day and focus on problems at intersections of units.	Administrator of the day identifies responsible party(ies) for each concern and sets clear follow-up strategies.

Chart adapted from: *Huddling for high reliability and situation awareness*

# HRO METHODS | EXEC ROUNDING

**Executive rounding to build trust and relationships.** Regular rounding can help leaders develop a deeper understanding of how processes are being carried out on a daily basis. During rounding, leaders observe activity and talk with staff at all levels, using the time to uncover which processes are working and which ones are posing problems, wasting time and introducing risk into the equation. The chart below, from “Executive Rounds for Safety,” shows how leadership rounding can help to create a culture of safety.

TYPE	LEAD	PARTICIPANTS	OBJECTIVE
<b>EXECUTIVE ROUNDS</b>	Senior executives (the CEO/“C” suite)	Front line staff, students (also consider Board members, patient advisors)	<ul style="list-style-type: none"> <li>• Enhance climate of trust</li> <li>• Discuss progress on key performance metrics</li> <li>• Surface/address issues identified by staff</li> <li>• Recognize accomplishments and progress</li> <li>• Remove barriers to communication and process improvement</li> <li>• Strengthen accountability processes</li> </ul>
<b>ROUNDS W/DIRECT REPORTS</b>	All leaders with direct reports	Direct reports	<ul style="list-style-type: none"> <li>• Further strengthen relationship between managers and those who report to them</li> <li>• Identify and recognize what is going well</li> <li>• Identify opportunities to support staff</li> </ul>
<b>LEADER ROUNDS W/ INTERNAL CUSTOMERS</b>	Support staff leaders who provide services to other departments	Staff in units receiving service from support departments	<ul style="list-style-type: none"> <li>• Build relationships with internal customers</li> <li>• Learn what is working well and what could be further improved</li> <li>• Improve level of service provided to internal customers</li> </ul>
<b>NURSE EXECUTIVE ROUNDS</b>	Nurse leaders (e.g. CNO, nursing directors/managers and charge RNs)	Patients and families	<ul style="list-style-type: none"> <li>• Assess quality of care and service from patient/family perspective</li> <li>• Identify what is going well</li> <li>• Identify what could/needs to be improved</li> <li>• Provide any needed service recovery</li> <li>• Increase patient/family confidence in care</li> </ul>
<b>PHYSICIAN ROUNDS</b>	Physicians with active patients	Patients and families	<ul style="list-style-type: none"> <li>• Assess status of patient’s care</li> <li>• Discuss key care issues with patient and family</li> </ul>



# HRO METHODS | SWARMinG

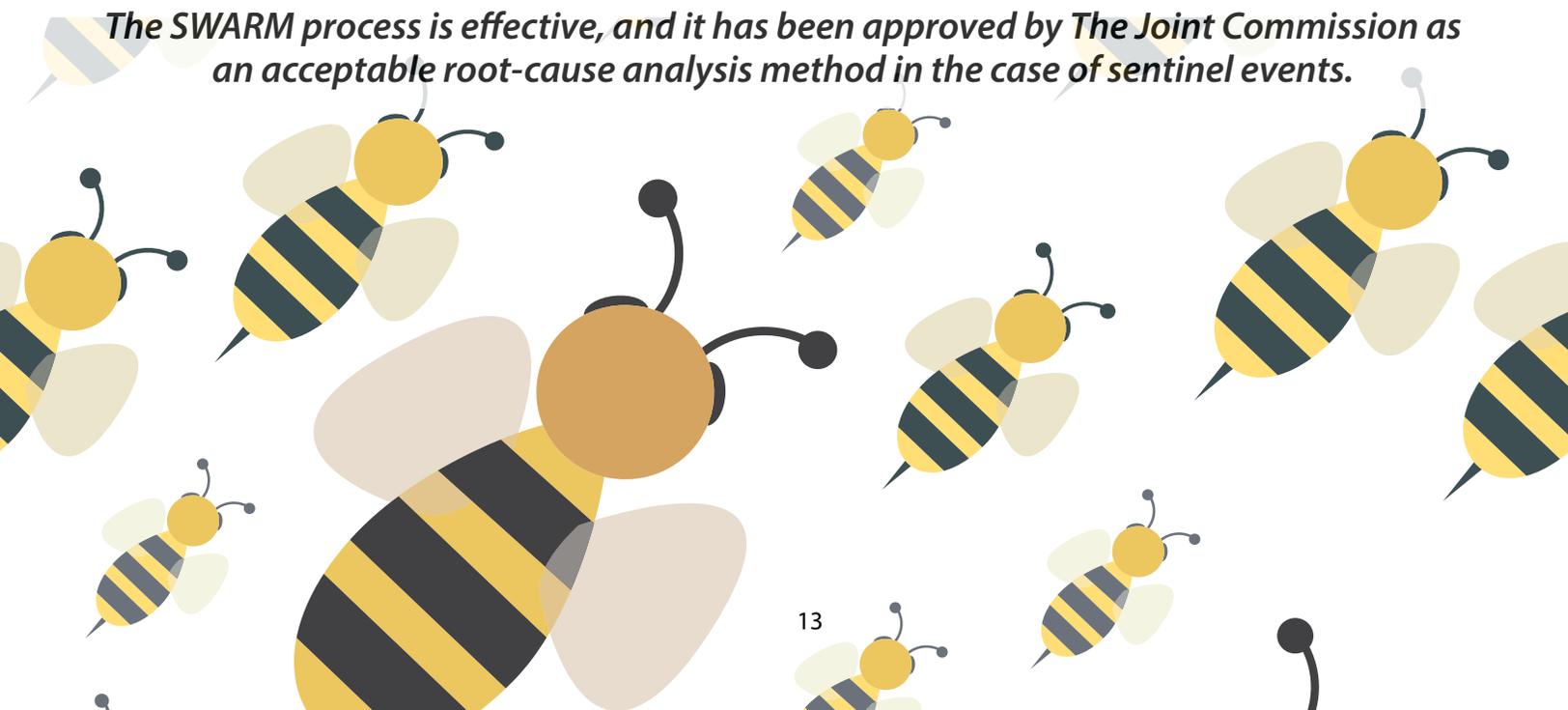
**SWARMinG to contain problems.** UK Healthcare developed the SWARMinG process from a combination of NASA's root-cause analysis method, the Veterans Administration triage cards and Toyota's lean management principles. Named for the collective action bees exhibit, the SWARM technique in the healthcare setting calls for staff to swarm to the site as soon as an adverse event occurs, identify the cause and determine the appropriate corrective action.

The **SWARM technique** includes the following five steps:

1. Encouraging candor by reassuring participants that they are in a blame-free environment with legal protections
2. Introducing all participants to create a common familiarity and respect
3. Reviewing the facts that prompted the SWARM
4. Discussing what happened and theorizing about why and how it happened
5. Proposing focus areas for action and assigning task leaders with specific deliverables and completion dates

One person leads the process and makes sure all assigned tasks are completed and ready for review within 60 days after the event.

*The SWARM process is effective, and it has been approved by The Joint Commission as an acceptable root-cause analysis method in the case of sentinel events.*





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