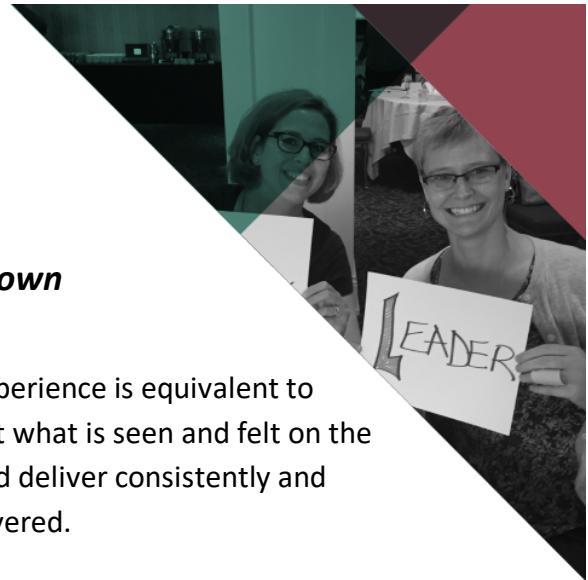


# SOLUTION: Becoming a Highly Reliable Organization



***“Don’t find fault. Find a remedy.” -Unknown***

To focus on customer service as the only key to a great patient experience is equivalent to “painting the shack.” A great patient experience isn’t simply about what is seen and felt on the surface related to service aspects. The encounter must be safe and deliver consistently and competently on high standards for the quality of the services delivered.

In healthcare, we have strived for many years and in a variety of ways to make the care we deliver safer for the patients we serve.

Even with the documented improvements, denying that serious deficiencies still exist is not a fantasy our industry can afford. We still have much work to do to overcome the unwarranted variation that is endemic in health care as evidenced by the report that was published on May 3, 2016. The findings of analyzing the medical death rate data over an eight-year period, Johns Hopkins patient safety experts calculated that more than 250,000 deaths per year are due to medical error in the U.S.

***This figure suggests that 10 percent of all U.S. deaths are now due to medical error and surpasses the U.S. Centers for Disease Control and Prevention’s third leading cause of death, respiratory disease, which kills approximately 150,000 people per year. Medical errors are the third leading cause of death in the US - falling behind the number one and two causes, heart disease and cancer respectively.***

Heart Disease, Cancer, Then US. We are the third leading cause of death in our country. It is time to put an end to that!

Things that should ***always*** happen, ***always*** happen.

Things that should ***never*** happen, ***never*** happen.

High Reliability Organization (HRO) concepts are not improvement methodologies like Plan-Do-Check-Act or Lean; instead, they are insights into how to think about and change the quality and safety issues your organization faces.

What we love about the high reliability efforts in healthcare is that organizations are proving that it can be done. We can achieve zero harm. Procedures that in the past were deemed as having a “normal” or “accepted” level of risk of complication or harm are now being done with zero defects, errors, or complications. Examples are abounding related to the elimination of bloodstream infections in patients with central lines and the absence of the complication of pneumonia in patients on a ventilator.

What makes a highly reliable organization? There is no cookie cutter answer, and no sprinkling of pixie dust to make your organization highly reliable. Due to the extremely complex nature of the work that we do each day, employees, leaders, physicians, providers, and the patients themselves must work together to “find the magic” that equates to a zero-harm environment.

Then, when that magic is found, the circumstances evolve, or change. Therefore, we can never stop trying to achieve zero harm, and celebrate, celebrate, celebrate along the way when we do!

## HERE ARE SOME FACTORS THAT LEAD TO HIGH RELIABILITY FOR YOU AND YOUR TEAM TO CONSIDER:

- **Is preventing Harm a strategic priority?**

You are reading this Solution, and hopefully have an employee driven team dedicated to “Safety is Job One”. Speak Up! If there is not an organizational goal and strategy dedicated to your team’s work - ask for one!

- **Leader and Employee Development.**

Leaders are not EVERYTHING needed to create a zero defect, zero harm environment, but a leadership culture of learning HOW to make zero harm happen is key to success. Leaders (and employees) need to have training on the following key topics:

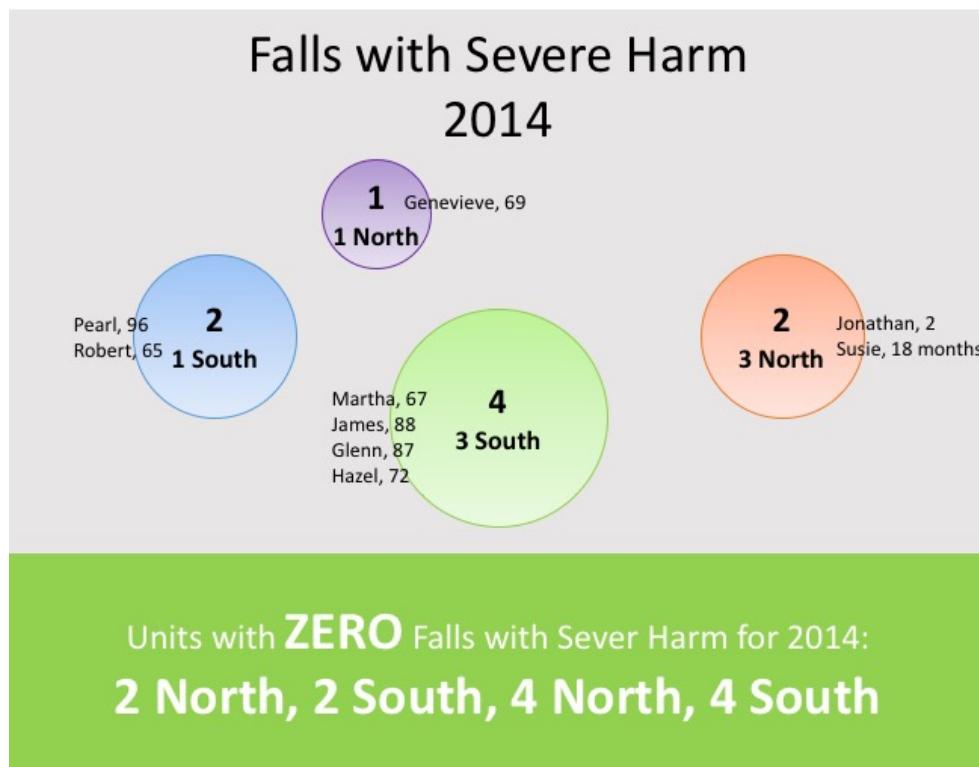
- Emotional Intelligence
- Improvement Methodologies (PDSA, Lean, Six Sigma)
- Improvement Tools and Tactics (Huddles, briefings, validation rounds, TEAMStepps, CUSP, Learning from Defects)
- Measurement and Reporting: **Generate light, not heat, with data.**

## ***Measure and transparently report fewer things better.***

Truly evaluate what you need to report, and where the data goes, and the worth it serves. THEN, go after data you can truly use to serve great decisions and reporting to make the patients safer.

Use stories to make data real. A harm Bubble is a great example of making the data real.

What will happen then, is that those present while you report data will not celebrate “GREAT- we only had one fall with harm this month”. Instead they will empathize with Genevieve the patient who fell and suffered at the hands of our organization”.



When creating a Leadership priority for zero defect and zero harm, the key tactic of Rounding has a valuable place. When leaders focus their time on safety as a priority, employees will notice that their voice regarding safe patient care is a priority as well.

## FRONTLINE AND SENIOR LEADERSHIP ROUNDING ON EMPLOYEES ASKING THE FOLLOWING QUESTIONS:

### Rounding Questions:

- “What keeps you awake at night regarding patient safety?”
- “Can you tell me about the last “good catch” or safety improvement you’ve been part of?”
- “Can you tell me about the last patient that would have been harmed without your intervention?”
- “Can you tell me about the next patient that may be harmed and your ideas to prevent that?”
- “Are there any safety issues happening in our department that I should be aware of?”

## YOUR CALL TO ACTION.

The most important thing you can do to strive and work toward becoming a more highly reliable organization is to DO SOMETHING. JUST START. Again, there is no clear recipe, each organization is different. Likely you are measuring safety and quality in the same way you have been for years. In today’s environment, the words “We have always done it this way” needs to be banished.

Instead, see safety, quality and zero harm through new, innovative lenses and JUST START.



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