HARRISHEALTH

Participant Guide

OUR HIGH RELIABILITY ORGANIZATION JOURNEY

- Preoccupation with Failure
- Sensitivity to Operations
- Reluctance to Simplify
- Commitment to Resilience
- Deference to Expertise

ZERO HARM

HIGH RELIABILITY MODEL FOR HEALTHCARE

Chassin MR, Loeb JM. High-Reliability Health Care: Getting There from hear. MILB Q 3;91(3):459-90

The paper "High-Reliability Health Care: Getting There from Here" by Mark R. Chassin and Jerod M. Loeb provides insights into the application of high-reliability principles from other industries (such as aviation and nuclear power) to healthcare. Chassin and Loeb's model for high-reliability healthcare identifies three interrelated domains that are essential for a healthcare organization to achieve high reliability.

1) **Leadership:** Leadership must prioritize and actively promote patient safety, aiming for zero incidents.
2) **Safety Culture:** An environment where all staff prioritize and feel responsible for patient safety, and are encouraged to report and learn from errors without fear of blame.
3) **Robust Process Improvement:** Continual refinement of healthcare processes using tools from methodologies like Six Sigma and Lean to ensure consistent, safe outcomes.

OUR WHY FOR THE HRO JOURNEY

- To support our mission, vision and values at Harris Health
- At the patient level: health outcomes and patient experience.
- At the employee level: psychological safety, partnership, respect, and employee experience.
- At the organization level: shared leadership, better outcomes, and improved health system for our community.

OUR GOAL

- Zero Preventable Harm

PARTNER ACTIVITY

Have you or a loved one been harmed in a healthcare setting?

1. **Preoccupation with Failure**
   - HROs focus on failure.
   - They focus on anomalies that could be symptoms of a larger problem.
   - They look deeper into incidents to find underlying causes.
2. **Sensitivity to Operations**
   - HROs do not assume that the outcomes will be the same as planned.
   - HROs pay close attention to operations and maintain awareness of what is and what is not working.
   - HROs do not make assumptions.
   - HROs ask questions.
   - HROs use data to make decisions and track outcomes.
3. **Reluctance to Simplify**
   - Simple processes are good, but simplistic explanations for why things work or fail are risky.
   - Avoiding overly simple explanations of failure is essential to understand the true reasons patients are placed at risk.
   - Look for the "Swiss Cheese."
4. **Commitment to Resilience**
   - HROs are adaptable, learning organizations.
   - Do not let failure disable your operations.
   - React appropriately, even under unanticipated conditions.
   - Recognize emerging anomalies by keeping an open mind.
5. **Deference to Expertise**
   - The "expert" is the person with hands-on knowledge of the operation at the point of failure.
   - Give your experts access to upward reporting.
   - Leaders must listen to those experts, regardless of seniority.

PATIENT SAFETY CENTERED CULTURE

A culture where people feel safe raising questions and concerns and report safety events in an environment that emphasizes a non-punitive response to errors and near misses.

INTEGRATION OF HRO AND JUST AND ACCOUNTABLE CULTURE

Clear lines are drawn between human error, at-risk, and reckless behaviors.

Human Error *Product of our current system design.*	**At-Risk Behavior** *A Choice. Risk believed insignificant or justified.*	**Reckless Behavior** *Conscious disregard of unjustifiable risk.*
Manage through changes to:	**Manage through**	**Manage through**
• Processes • Procedures • Training • Design • Environment	• Removing incentives for at-risk behaviors • Creating incentives for healthy behaviors • Increasing situational awareness	• Remedial action • Disciplinary action
Accept and Console	**Coach**	**Disciplinary Sanction**

COMMUNICATION

Communication is the response you get from the message you sent regardless of its intent.

According to **Sentinel Event** data compiled by the Joint Commission, **ineffective communication** was identified as the root cause of **66%** of reported errors.

Communication is the lifeline of a well-functioning team.

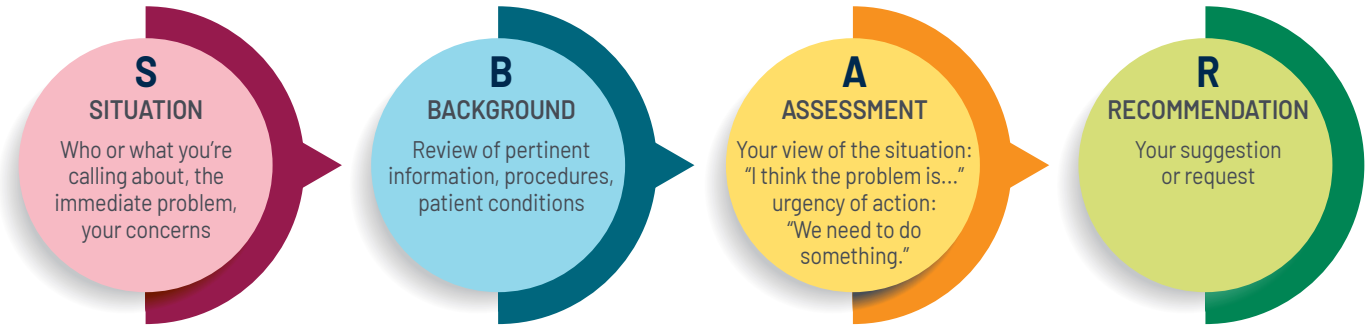
HRO COMMUNICATION TOOLS

Handoff Tool

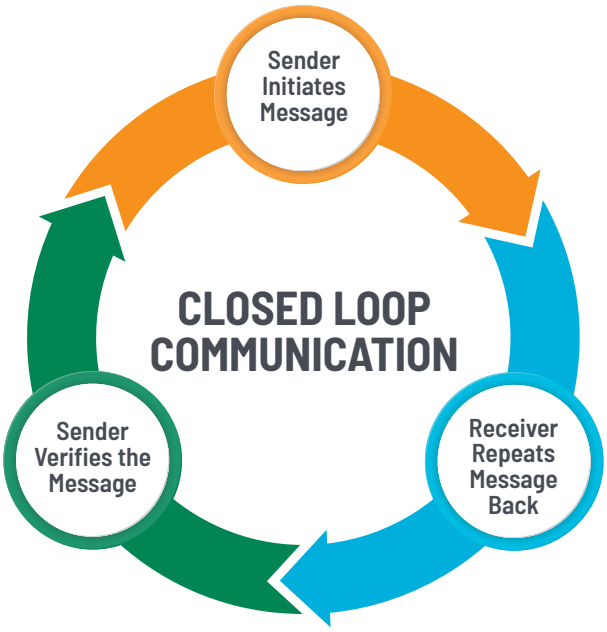
Whenever a patient changes locations or caregivers, a handoff should take place in order to ensure a smooth transition of care.

Use to effectively transfer responsibility and accountability for a patient's care.

SBAR



Closed Loop Communication



Alpha/Numeric Clarification

For ***sound alike words***, say the letter followed by a word that begins with the letter.

For example:

A	Alpha	**J**	Juliet	**S**	Sierra
B	Bravo	**K**	Kilo	**T**	Tango
C	Charlie	**L**	Lima	**U**	Uniform
D	Delta	**M**	Mike	**V**	Victor
E	Echo	**N**	November	**W**	Whiskey
F	Foxtrot	**O**	Oscar	**X**	X-Ray
G	Golf	**P**	Papa	**Y**	Yankee
H	Hotel	**Q**	Quebec	**Z**	Zulu
I	India	**R**	Romeo		

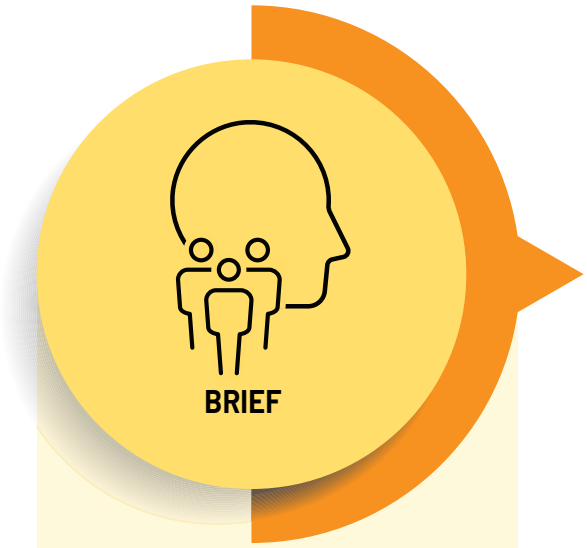
For sound alike numbers, say the number and then speak each digit of the number.

For example:

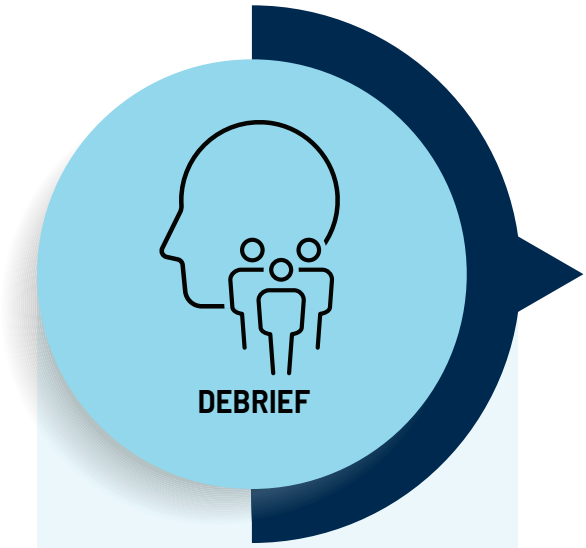
15...that's **one five**

50...that's **five zero**

Brief/Debrief



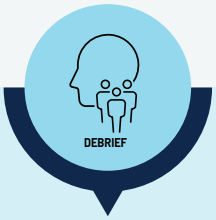
Routinely before the start of a shift, a planned procedure or an emergent event, a brief can help bring everyone up to speed on responsibilities, expectations and contingencies. Develop a checklist for your team to go over responsibilities, expectations, resources, contingencies and any lingering questions during the brief.



Coming together can help the team process what happened and identify what went well, what could be improved and one thing to do differently next time.

BRIEF CHECKLIST

- ___ Who is on the team?
- ___ Do all members understand and agree upon goals?
- ___ Are roles and responsibilities understood?
- ___ What is our plan of care?
- ___ What is staff and provider availability throughout the shift?
- ___ How is workload shared among team members?
- ___ What resources are available?
- ___ What matters to you related to the focus of the briefing?



DEBRIEF CHECKLIST

- ___ Was communication clear?
- ___ Were roles and responsibilities understood?
- ___ Was situation awareness maintained? (Did you know the plan?)
- ___ Was workload distribution equitable?
- ___ Was task assistance requested or offered?
- ___ Were errors made or avoided?
- ___ Were resources available?
- ___ What went well?
- ___ What one thing should improve?
- ___ What is one thing that could be done differently next time?

CUS

A responsibility we have to protect in a manner of mutual respect. Use the lightest touch possible...

If no success...
Use chain of command

ADDITIONAL HRO ACTIVITIES IN HEALTHCARE

Leadership Rounding

The process where leaders (e.g., administrators, department heads, and nursing leaders) are proactively and purposefully engaging with all staff by listening, communicating and support them. It is an effective method to collect vital information, support and engage staff, validate key behaviors, identify issues and reward and recognize good work.

Benefits of Leadership Rounding

- Builds trust and accountability
- Improves communication
- Boosts morale
- Recognizes staff
- Improves Processes

Safety Huddles

The Joint Commission says daily safety briefings, or huddles, as they often are called, are a hallmark of a high-reliability organization. Huddles include:

- Brief, daily discussions focusing on the plan of action.
- Discussion regarding patient safety and goals.
- Identification of problems that may have been overlooked for resolution.

Validate and Verify

Validate

- ✓ Does it make sense to me?
- ✓ Is it what I expected?
- ✓ Does this information "fit-in" with my past experience?

Verify

Check it with an independent, expert source:

- Patient
- Technology
- Professionals
- Procedures & References
- Medical Record Documentation

HRO LEADERSHIP SKILLSETS

- Non-hierarchical leadership
- Transparent and continuous communication
- Deference to expertise that promotes a shared leadership approach
- Ability to continuously innovate
- Motivation through Recognition
- Humble reflection of Self
- Assumes positive intent
- Commitment to Visibility
- Proactive role modeling of desired behavior

WHAT YOU CAN DO TODAY

- Speak up for safety and support your teammates to speak up
- Use the Electronic Information Reporting System- EIRS
- Use the HRO communication tools
  - Use the "CUS" tool *(I am concerned, I am uncomfortable, or this is a safety issue)* to escalate any safety concern you may have
- Review the weekly HRO Safety Sharing Alerts at every safety huddle
- Help to support and grow the HRO culture in your area

OUTCOMES OF OUR SUCCESS

- We observe and hear everyone using our high reliability tools.
- We learn about safety success stories – real life examples of Harris Health employees using HRO tools.
- The number of events of patient harm goes down and error free days go up.
- Quality and safety metrics improve.
- Physician//Nursing engagement improves.
- Patient experience improves.

RECOMMENDED RESOURCES

- Leading with Love: Staff & Leadership Development Series
- LEAD: Leadership Enhancement and Development
- Mission Retention
- Leadership Development Coaching
- Consulting and Customized Training
- Happy@Harris Health Emotional Intelligence Classes
- Executive Coaching Network - Leadership Effectiveness: Cycle of Trust—Assume Positive Intent
- Military Medicine - Promoting Psychological Safety in Healthcare Organizations
- American Society for Health Care Risk Management – The Necessary Leadership Skillsets for the High-Reliability Organization Framework Adoption within Acute Healthcare Organizations
- https://www.aha.org/center/project-firstline/teamstepps-video-toolkit