Curriculum Development Centers Program

Awardee of The Office of the National Coordinator for Health Information Technology

Unit 3: Reliability, Culture of Safety, & HIT

This material was developed by Johns Hopkins University, funded by the Department of Health and Human Services, Office of the National Coordinator for Health Information Technology under Award Number IU24OC000013.

Objectives

- Discuss reliability as a tool for ensuring safety
- Examine how ultra-safe organizations operate
- Identify how teams make wise decisions

Reliability

Image: http://www.pakalertpress.com

Video 1

Reliability

Evaluate → Calculate → Improve

Reliability

Prevent Failure

- Best practice guidelines, tools, techniques
- Awareness campaigns
- Memory aids
- Checklists
- Making the desired action the default

Reliability

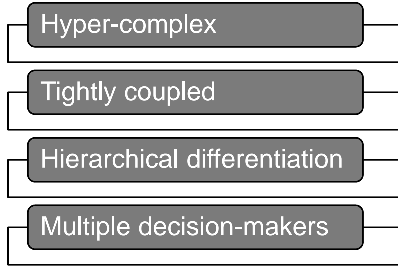
Identify and Mitigate Failure

- Reduce fatigue and distraction
- Standing orders for best practice treatments
- Electronic flags
- Independent double-checks

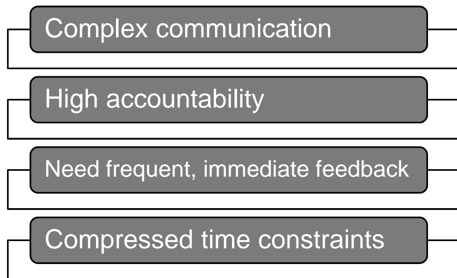
Redesign for Success

- Understand where the failure is occurring
- Determine the remedy

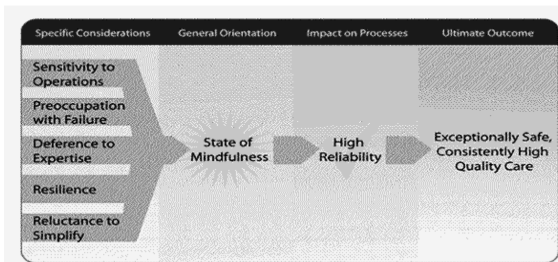
High Reliability Organizations



High Reliability Organizations

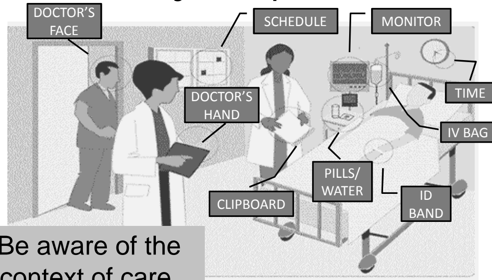


High Reliability Organizations Mindfulness



http://www.ahrq.gov/qual/hroadvice/hroadvicefig1-6.htm

High Reliability Organizations Sensitivity to Operations



Be aware of the context of care.

http://www.ahrq.gov/qual/hroadvice/hroadvicefig1-6.htm

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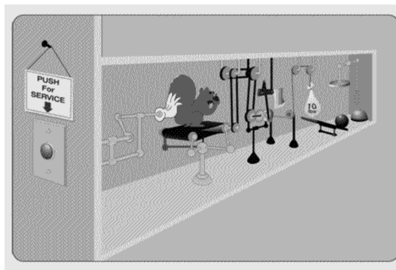
High Reliability Organizations Reluctance to Simplify

Keep things simple.



http://www.ahrq.gov/qual/hroadvice/hroadvicefig1-6.htm

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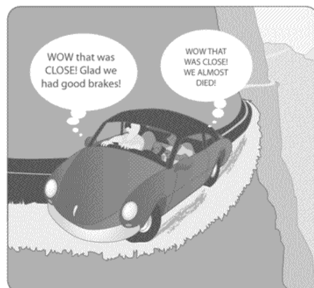
High Reliability Organizations Preoccupation with Failure

Be preoccupied with failure. Don't rely on good brakes to save you every time.



http://www.ahrq.gov/qual/hroadvice/hroadvicefig1-6.htm

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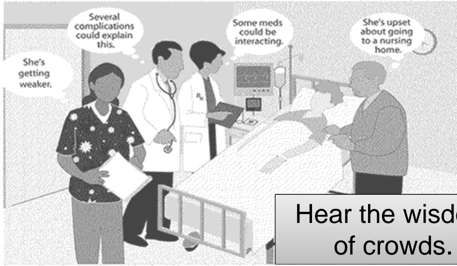
High Reliability Organizations Deference to Expertise



Hear the wisdom of crowds.

http://www.ahrq.gov/qual/hroadvice/hroadvicefig1-6.htm

High Reliability Organizations Resilience

Be prepared for failure. What can go wrong, will.

http://www.ahrq.gov/qual/hroadvice/hroadvicefig1-6.htm

Culture

"the shared perceptions of the individuals within the team or an organization about what is good, right, important, valued, supported, or expected at any given time."

Riley W. et al (2010)

The Blame Game

Pointing the finger at people rather than systems

Image: MS Clipart

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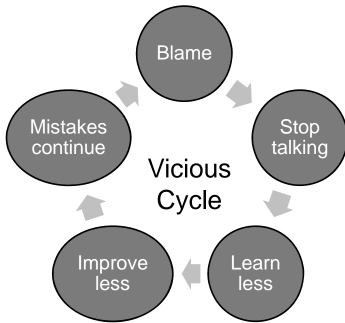
Blame



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Blame

- Limits learning
- Increases likelihood of repeat errors
- Drives self-reporting underground

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Just Culture

- Focuses on identifying and addressing systems issues that lead individuals to engage in unsafe behaviors
- Maintains individual accountability by establishing zero tolerance for reckless behavior
- Distinguished between human error, at-risk behavior, and reckless behavior
- Response to error or near miss is predicated on the type of behavior associated with the error, not the severity of the event

http://psnet.ahrq.gov/primer.aspx?primerID=5

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How to Promote a Culture of Safety

Accept responsibility

Value learning from mistakes

Learn to recognize risky behaviors

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How to Promote a Culture of Safety

Speak up if something is not right

Listen to others & discuss ways to prevent error

Take action to reduce risk

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How to Promote a Culture of Safety

Report errors & near misses

Encourage others to report errors & near misses

Help change unrealistic policies

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Culture of Safety Characteristics

Carefully LISTEN to the concern to determine if corrective action is necessary

Recognize when a concern is expressed by anyone and STOP

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Culture of Safety

http://static.guim.co.uk/sys-images/Environment/Pix/pictures/2008/05/09/honeybee460.jpg

Video 2

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