

High Reliability Organizing

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Why do we have a reliability gap?

1. Improvement excessively dependent on vigilance and hard work
2. Benchmarking to mediocre outcomes gives a false sense of reliability
3. Excessive clinical autonomy allows for wide and unjustifiable performance variation
4. Processes rarely designed to meet specific reliability goals

SECOND EDITION

MANAGING THE UNEXPECTED



Resilient Performance in an
Age of Uncertainty

KARL E. WEICK AND
KATHLEEN M. SUTCLIFFE

High Reliability

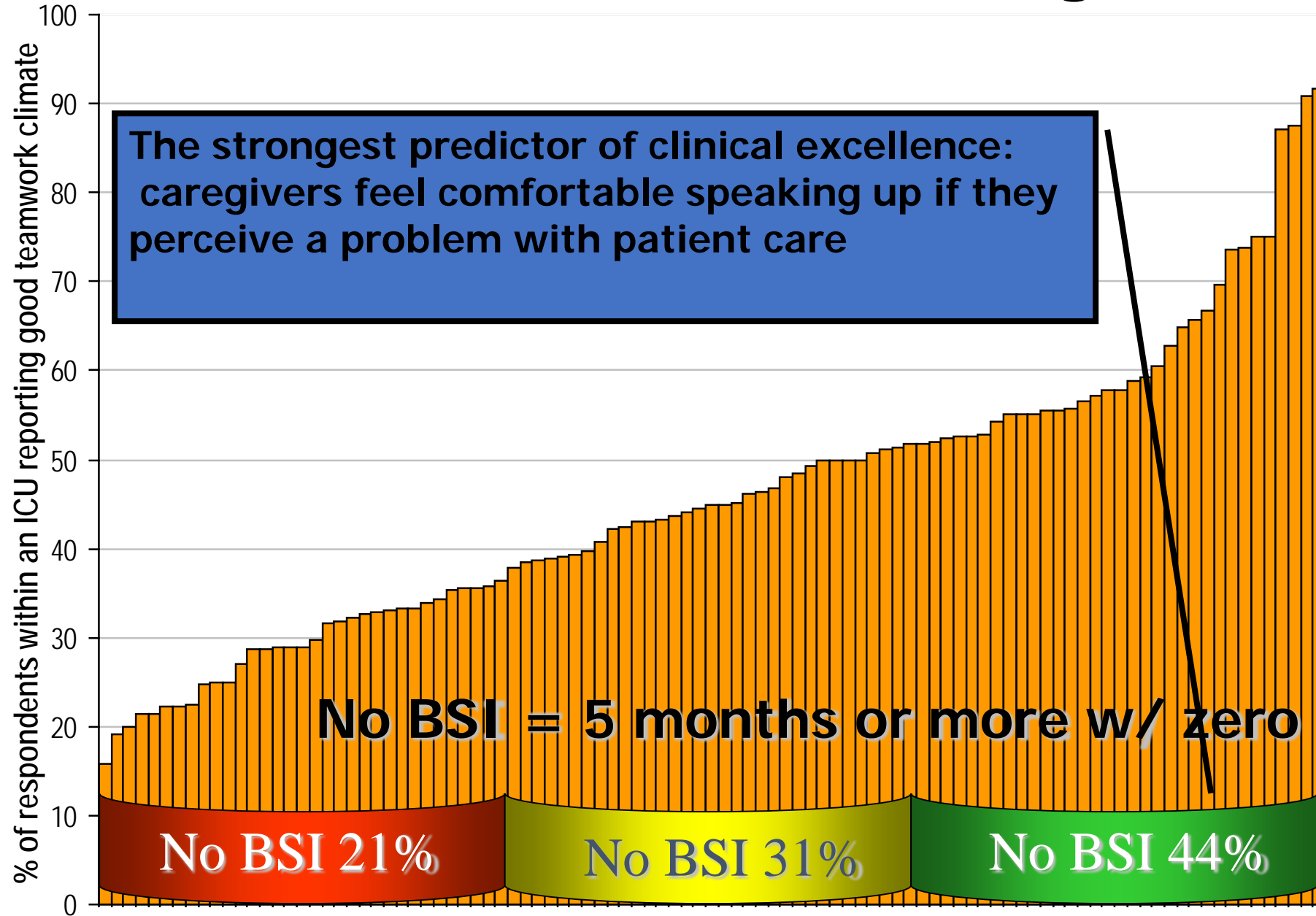
- Tracks small failures
- Resists oversimplification
- Is sensitive to operations
- Maintains capabilities for resilience
- Takes advantage of shifting locations of expertise

Sensitivity to operations



- Attentive to the front line
- “Big Picture” is less strategic and more operational
- Situational awareness
- Make adjustments that prevent errors from accumulating and enlarging
- People who refuse to ‘speak up” out of fear undermine the system

Teamwork Climate Across Michigan ICUs



Situational Awareness



- Environment & People
 - Attention to detail
 - Include all multidisciplinary team members including patients and family
 - Be proactive; anticipate potential risks “weak signals”
 - Promote teamwork and group understanding

Airline safety announcement

- “...must assist crew and help direct other passengers without being occupied with other intentions...”

SkyWest Flight Attendant
May 6, 2008





Preoccupation with Failure

- Encourage reporting of errors
- Treat any lapse as a symptom that something may be wrong with the system
- Focus on near-misses
- Are wary of potential liabilities of success
 - Complacency
 - Temptation to reduce margins of safety
 - Automatic processing

Making
Failure
Obvious

California Pacific Medical Center
Thursday October 16, 2008

RN: Maureen

RT: Jannette 232-6581

Oral care

08	10	12	14	16	18	20
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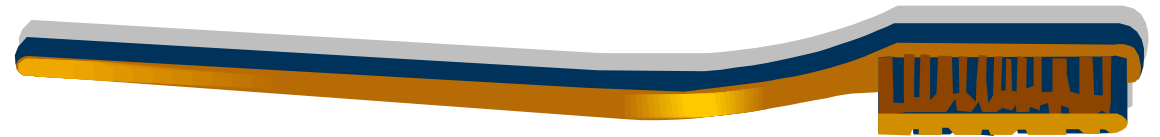
Making Failure Obvious



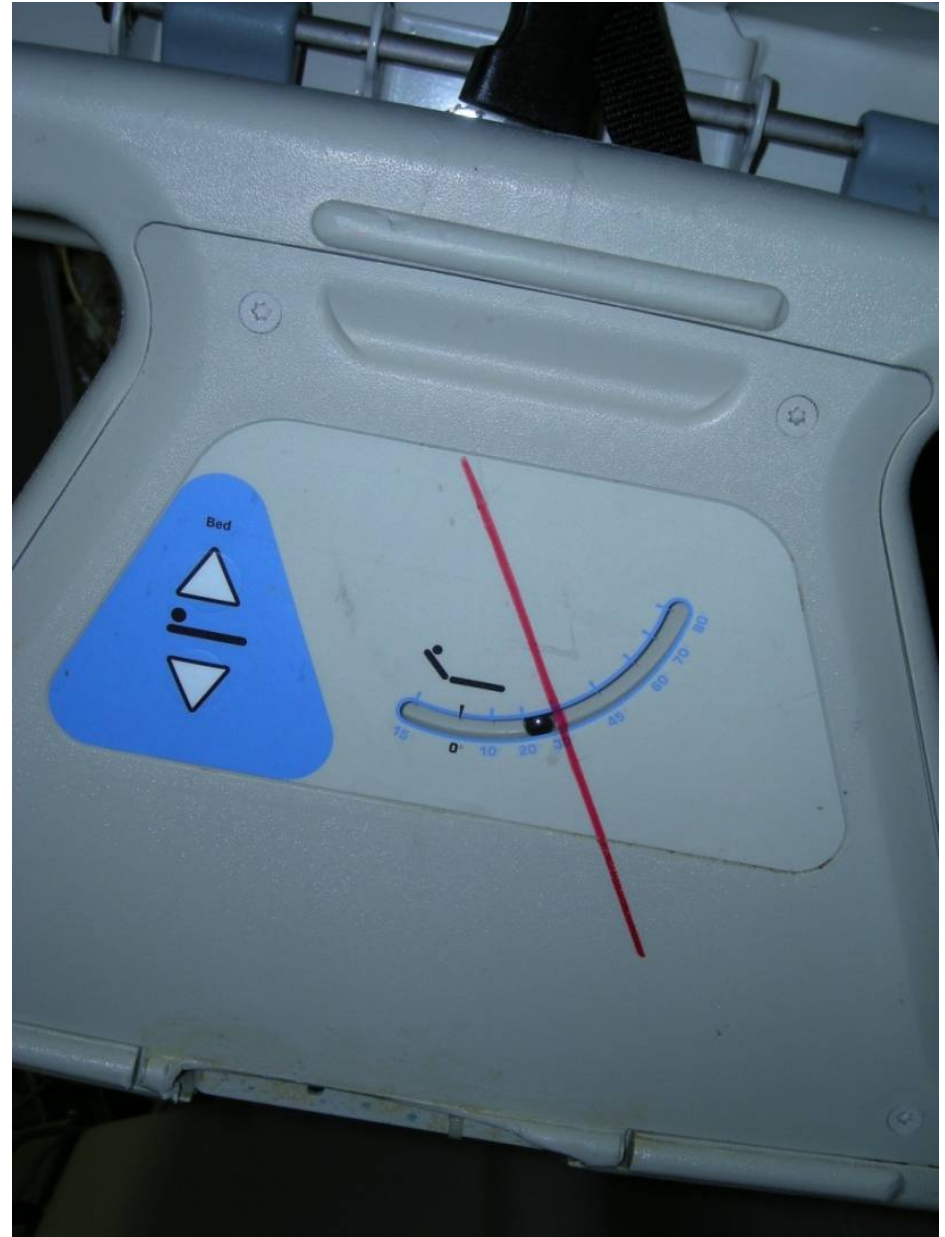
Making Failure Obvious



- Use of every-4-hour oral care kit
 - Only toothbrush should be left at 4AM
 - Staff held each other accountable



Making Failure Obvious



Making Failure Obvious

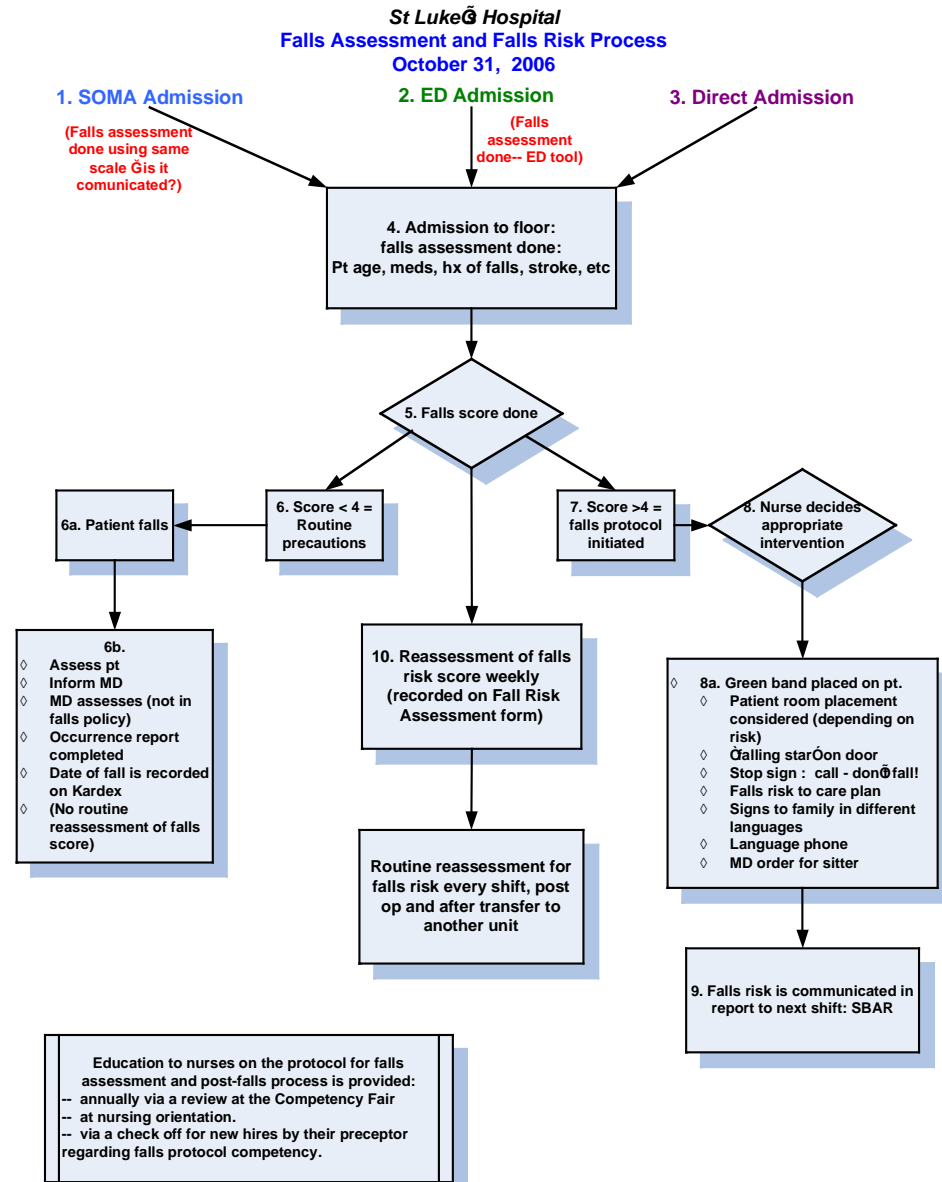


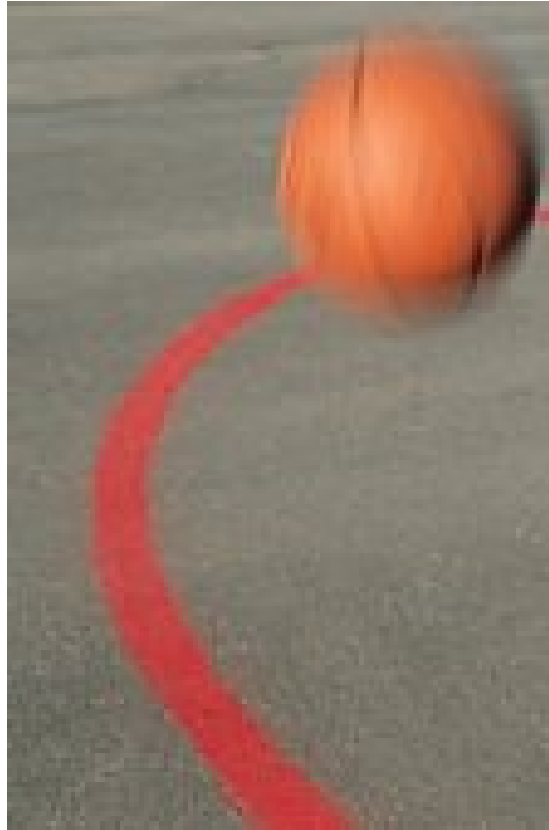


Reluctance to Simplify

- See as much as possible
- Welcome diverse experience, skepticism

Flowchart your current process





Commitment to Resilience

- Detect, contain and bounce back from inevitable errors
- Errors don't disable
- Combination of keeping errors small and improvising workarounds that allow the system to keep functioning



Deference to Expertise

- Push decision making down and around
- “experience” not always a guarantee of expertise
- Awareness of others limitations and fallibilities