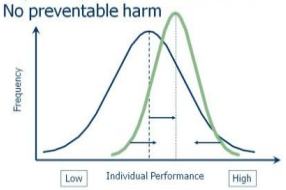
How to Remove Barriers to High Reliability

When American healthcare leaders confront the basic requirements for achieving high reliability in quality and safety in light of the prevailing dysfunctional practices, they will open the door to transformation. Organizational culture is the province of leadership and also the crux of the problem. With much waiting to be accomplished, the greatest leverage can be obtained by focusing initially on self-reporting of adverse events, near misses and hazardous conditions – a visible, measurable behavior which epitomizes engagement in safety - in conjunction with adoption of best practices in event analysis and peer review. If you accept the challenge of high reliability, use this storyboard to your advantage.

The Aim of High Reliability

- Radically reduced variation
- Improved performance and value
- No preventable harm



Requirements

- Sr. management knows how to nurture organizational learning & improvement
- Sr. management actively leads the way
- Quality valued "First among Equals"
- Collective "Mindfulness"
  - ✓ Anticipate, recognize and rapidly act to contain unexpected threats to safety in dynamic, high-risk environments
  - ✓ Value a strong response to a weak signal
- Improvement activity is wide and deep
- Wholesale candor and diligence in reporting problems and risks
- Rapid cycle non-punitive event analysis
  - ✓ Focused on system process learning opportunities with default presumption of staff innocence & competence
- "Stop the Line" events immediately attract resources to resolve
- Changes are studied to assure their effectiveness
- Incentives are aligned with safety

Prevailing Practice

- Lack of leadership for high reliability
- High reliability not a top priority
- Too much avoidable harm
- Gross under-reporting of adverse events, near misses and hazardous conditions
- Deficit of QI knowledge & skill
- Physicians & staff poorly engaged in safety
- Much change without improvement

Perfect System for Casting Blame

Hospital Survey on Patient Safety Culture

The Dysfunctional QA Model for Clinical Peer Review

- Perpetuates a culture of blame
- Fails to improve performance

Best Practice

QI Model Clinical Peer Review

Clinical peer review among physicians and among nurses and their managers is the primary method of event analysis in US hospitals – and is the chief factor perpetuating a culture which is hostile to high reliability.

A best practice model that incorporates self-reporting and QI principles has been well-characterized and validated, but is infrequently being applied despite a high rate of program change.

QA vs. QI Model Peer Review

	QA Model	QI Model
Focus	Outliers	Shift the curve
Identify	Substandard care	Learning opportunity
Determine	Competence	Performance
Inputs	Single case	Multiple cases
Process	Variable	Standardized
Relation to PI	Disconnected	Highly interdependent
Method	Judgment	Performance measurement
Reliability	Low	Good
Accountability	Low	High
Net Effect	**Blame Culture**	**Safety Culture**

Know Your QI Model Score

https://qatoqi.com/php/self-assessment.php

- Median QI Model Score: 50 (N = 270)
  Range: 0 – 96
- The score predicts the likelihood of significant ongoing contribution to quality and safety:
  $R^2 = 51.7\%$
- 10 point increase predicts higher quality impact
  Odds Ratio [95% CI]: 2.5 [2.2 – 3.0]
- 8% score ≥80 → **All Need to Improve**
- 71% score <65

The Necessary Actions

Promote Self-Reporting

- Promise protection from disciplinary action for self-reporting, in the absence of reckless disregard for patient safety
- Guarantee the promise
- Make it easy to report
- Explain the rationale
- Encourage, recognize and reward self-reporting
- Assure a non-punitive, learning-focused event analysis process
- Produce visible improvements

Why Focus on Self-Reporting?

- Simplest path to change the culture
- Solves the problem of event identification
- Mandates a non-punitive response to error
- Removes blocks to clinician engagement
- Reveals professional vulnerability to system defects
- Invites analysis of causes and preventive strategies
- Supports greater inter-disciplinary teamwork
- Offers solace to the 2nd victim
- Builds on familiar processes
- Requires minimal investment

Reference

In Pursuit of Quality and Safety: an Eight-Year Study of Clinical Peer Review Best Practices in U.S. Hospitals. Int J Qual Health Care. doi:10.1093/intqhc/mzy069

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