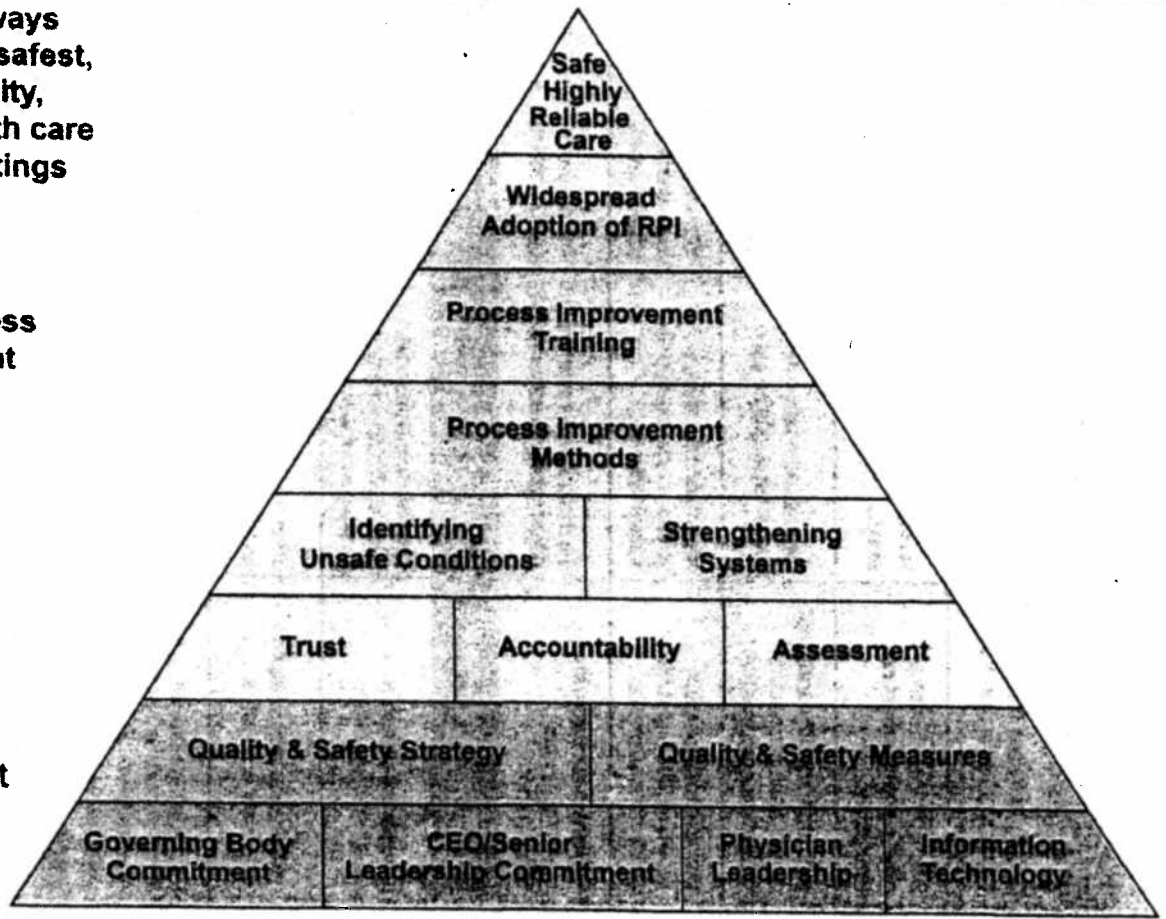
# Building Blocks to Achieving High Reliability

All people always experience the safest, highest quality, best value health care across all settings

Robust Process Improvement

Safety Culture

Leadership Commitment




Compliance with Joint Commission Standards & National Patient Safety Goals
Excellent Accountability Measure Performance

The Joint Commission

# Stages of Development on the Pathway to High Reliability

**(Consistency of Safety & Quality Performance over Long Periods of Time)**

| | Beginning | Refining | Maturing | Circle One in Each Box Below |
|---|---|---|---|---|
| **Leadership** | | | | |
| Quality Activities | Quality activities focused on regulatory requirements | Chief executive officer leads proactive quality agenda | Organization commits to goal of high reliability for all clinical services | Beginning Refining Maturing |
| Quality Prioritized | Strategic importance of quality improvement not recognized | Board reviews adverse events | Organization aims for near zero failure rates in some vital clinical processes | Beginning Refining Maturing |
| Quality Rewarded | Metrics for quality goals not part of strategic plan or incentive compensation | Organization sets a few measurable quality aims | Staff rewards system prominently reflects quality goals accomplishments | Beginning Refining Maturing |
| Information Technology Support | Information technology provides little support for quality improvement | Information technology supports some quality & safety initiatives | Information technology integral to sustaining quality improvement | Beginning Refining Maturing |
| Physician Engagement | Physicians not actively engaged in quality improvement | Physician leaders champion quality goals in some areas | Physicians routinely lead quality efforts | Beginning Refining Maturing |
| **Safety Culture** | | | | |
| Safety Culture Program | No specific program to assess safety culture | Establishing safety culture accorded high priority by leaders at all levels | Safety culture is well established | Beginning Refining Maturing |
| Safety Culture Implementation | No assessment of trust or intimidating behavior | First measures of safety culture deployed | Measurement of safety culture is well established | Beginning Refining Maturing |
| Safety Culture Embedded | Root cause analyses limited to most serious adverse events; close calls not recognized or evaluated | Beginning initiatives to encourage reporting and analysis of close calls | Regular reporting of close calls and unsafe conditions leads to early problem resolution | Beginning Refining Maturing |
| **Process Improvement** | | | | |
| Use of Improvement Tools (e.g. Lean, Six Sigma) | No formal quality management/improvement system | Organization commitment to strong quality improvement tools | Improvement Tools used throughout organization | Beginning Refining Maturing |
| Engagement in Process Improvement | External requirements are focus of improvement efforts | Beginning training of selected staff in Process Improvement Techniques | Organization & PATIENTS engaged in redesigning care processes | Beginning Refining Maturing |
| Mandatory Implementation of Process Improvement | No commitment to sustainable improvement | Improvement Tools used to achieve gains in quality & safety in addition to routine business processes | Mandatory technique training of all staff & proficiency required for career advancement | Beginning Refining Maturing |