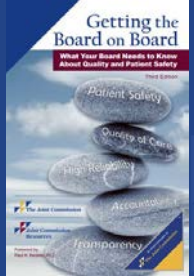
SAFETY CULTURE AND HIGH RELIABILITY: STAGES OF ORGANIZATIONAL MATURITY



The following was excerpted from Getting the Board on Board: What Your Board Needs to Know About Quality and Patient Safety, Third Edition. Order your copy today.

SAFETY CULTURE	Beginning	Developing	Advancing	Approaching
Trust	Trust or intimidating behavior is not assessed	First codes of behavior are adopted in some clinical departments	CEO and clinical leaders establish a trusting environment for all staff by modeling appropriate behaviors and championing efforts to eradicate intimidating behaviors.	High levels of (measured) trust exist in all clinical areas; self-policing of codes of behavior is in place.
Accountability	Emphasis is on blame; discipline is not applied equitably or with transparent standards; no process exists for distinguishing "blameless" from "blameworthy" acts.	The importance of equitable disciplinary procedures is recognized, and some clinical departments adopt these procedures.	Managers at all levels accord high priority to establishing all elements of safety culture; adoption of uniform equitable and transparent disciplinary procedures begins across the organization.	All staff recognize and act on their personal accountability for maintaining a culture of safety; equitable and transparent disciplinary procedures are fully adopted across the organization.
Identifying unsafe conditions	Root cause analysis is limited to adverse events; close calls ("early warnings") are not recognized or evaluated.	Pilot "close call" reporting programs begin in a few areas; some examples of early intervention to prevent harm can be found.	Staff in many areas begin to recognize and report unsafe conditions and practices before they harm patients.	Close calls and unsafe conditions are routinely reported, leading to early problem resolution before patients are harmed; results are routinely communicated.

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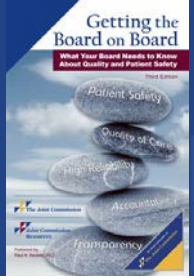

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Strengthening systems	Limited or no efforts exist to assess system defenses against quality failures and to remedy weaknesses.	Root cause analyses begin to identify the same weaknesses in system defenses in man clinical areas, but systematic efforts to strengthen them are lacking.	System weaknesses are catalogued and prioritized for improvement.	System defenses are proactively assessed, and weaknesses are proactively repaired.
Assessment	No measures of safety culture exist.	Some measures of safety culture are undertaken but are not widespread; little if any attempt is made to strengthen safety culture.	Measures of safety culture are adopted and deployed across the organization; efforts to improve safety culture are beginning.	Safety culture measures are part of the strategic metrics reported to the board; improvement initiatives are underway to achieve a fully functioning safety culture.

Source: Chassin M, Loeb L. High-reliability health care: Getting there from here. Milbank Q. 2013 Sep; 91(3):459–490. Accessed Aug 27, 2016. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3790522/pdf /milq0091-0459.pdf.