HRO -
Using HRO Drivers to Drive Success

Agenda

Introduction

Overview of HRO Drivers

It all Fits

Swarm

Closing



Introduction







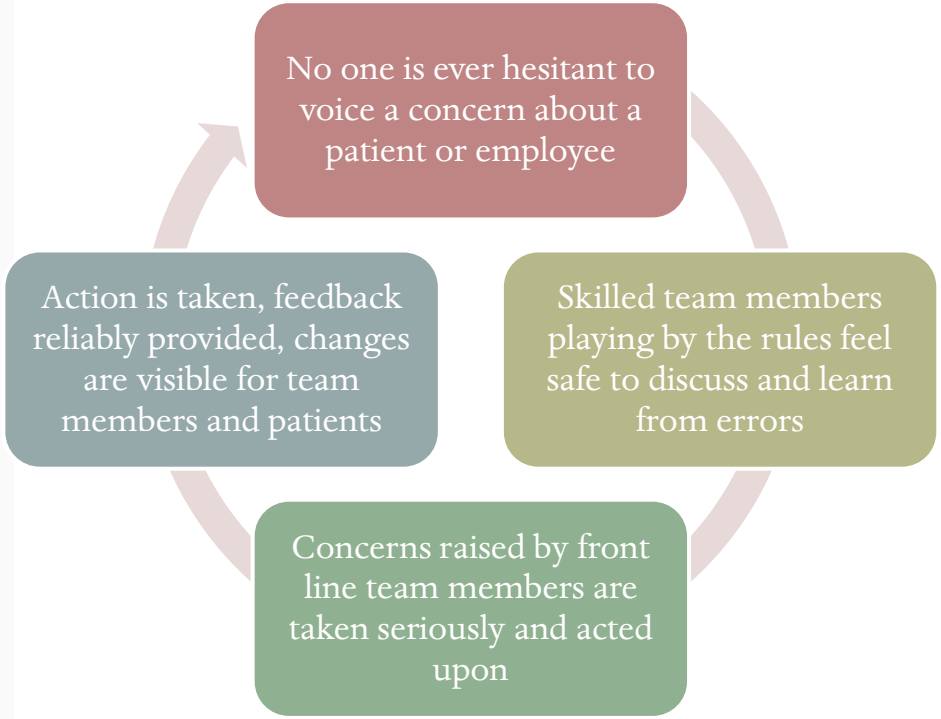
My Why



Patient Safety Cycle



A Culture of Safety:



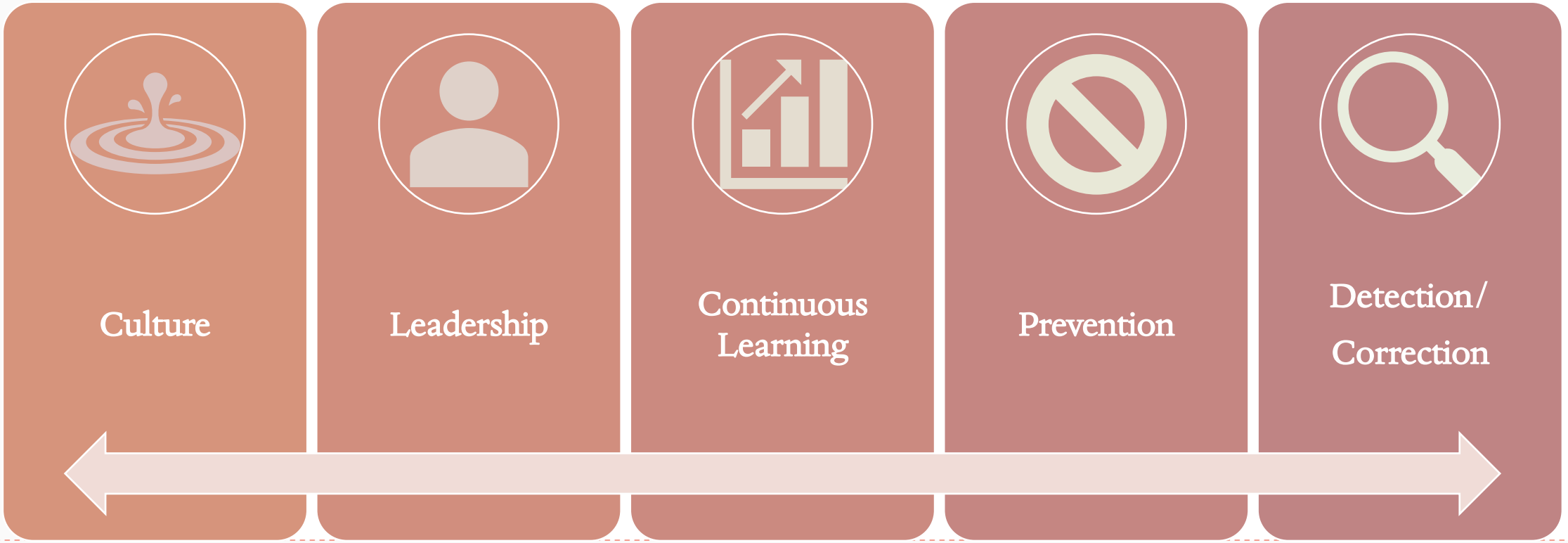
Before you can get on the cycle you must have:

- Psychological Safety
- Just Culture
- Flat Power Distance

HRO Driver Overview



High Reliability Organizing in Healthcare



HRO Drivers

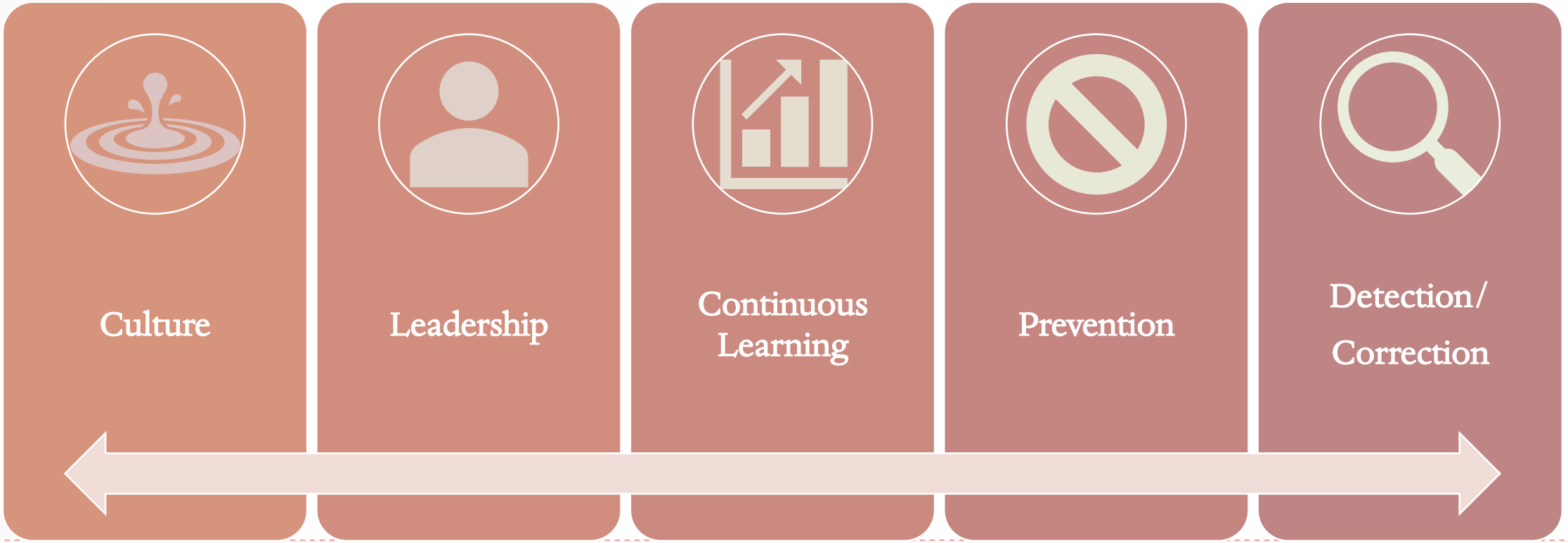
Culture	• Psychological Safety • Teaming • Reporting Culture • Sharing the Why
Leadership	• Just Culture • Flat Power Distance • Accountability • Leader Rounding
Prevention	• Universal Skills • Reporting • Identifying and Mitigating Risks • Bundles
Detection / Correction	• Responding to events • Cause Solving • Sustaining Change • Detection Systems
Continuous Learning	• Learning mindset • Robust Process Improvement • Questioning Status Quo

It All Fits Together

How reliability science can be the foundation to solve the problems you face



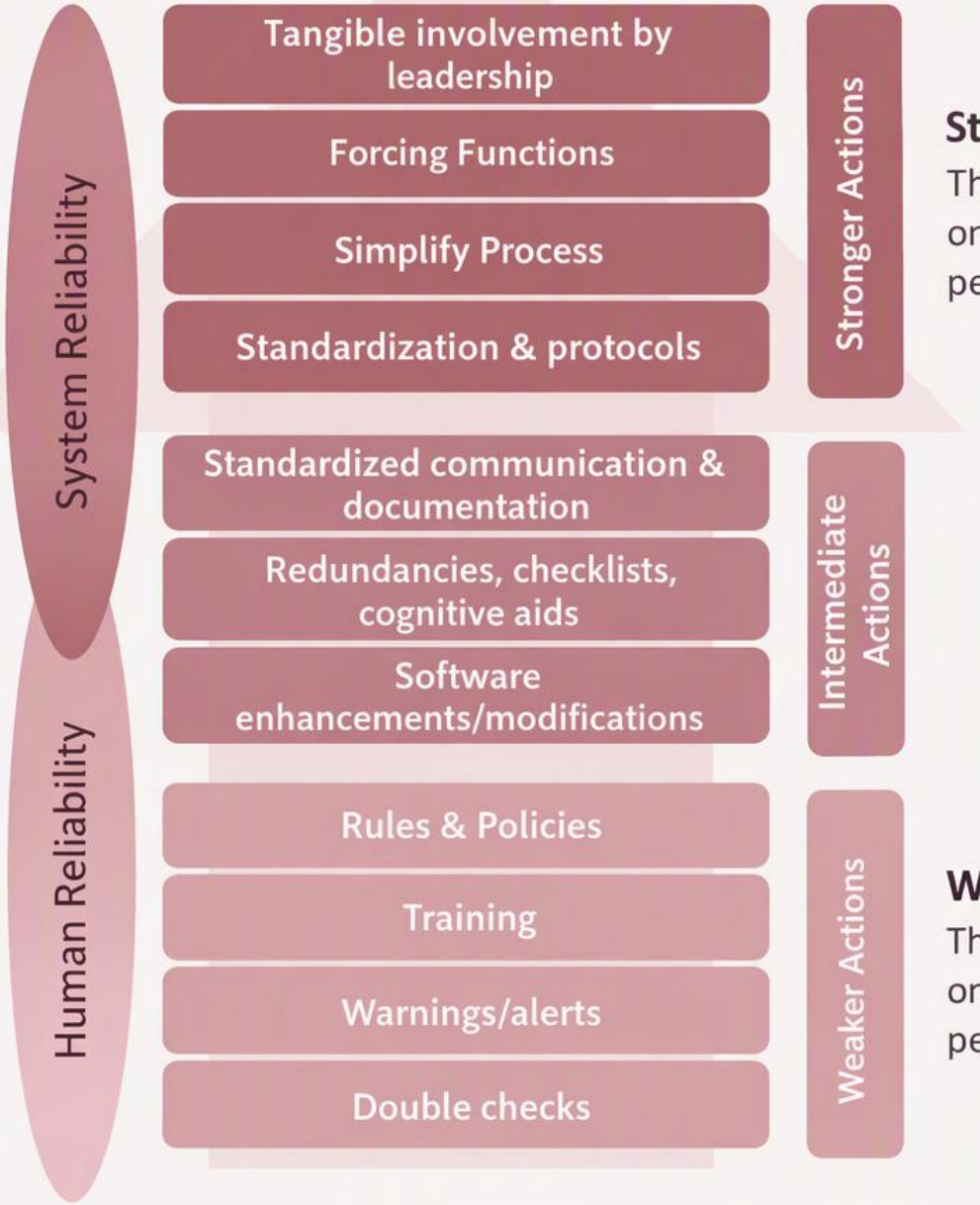
High Reliability Organizing in Healthcare



Hierarchy of Effectiveness

Most Effective

Hardest to Implement



Least Effective

Easiest to Implement

Stronger Actions

These tasks require less reliance on humans to remember to perform the task correctly

Weaker Actions

These tasks require more reliance on humans to remember to perform the task correctly

Action Hierarchy levels and categories are based on Root Cause Analysis Tools, VA National Center for Patient Safety, http://www.patientsafety.va.gov/docs/joe/rca_tools_2_15.pdf.

It All Fits Together

Case Studies



Reducing CAUTI



Culture

- Shared the vision
- Explained the risk to the patient and outcomes
- Ensured that nurses and physicians knew what their role was
- Rounding
- Discussion in real time about Foley's in place with both providers and nurses



Leadership

- Leadership rounding
- Leadership accountability
- Leadership set goal
- Department chief engaged in improvement



Prevention

- Early removal
- Reduce culturing
- Changed policy related to culturing off of catheter
- CAUTI prevention bundle
- K card rounding



Detection/Correction

- Deep dives in all CAUTI's
- Remove catheters if not absolutely necessary
- If any fall outs on the CAUTI bundle identified during K card rounds, corrected in real time and discussed with nurse or provider



Continuous Learning

- A3 in place
- Clear action plan
- K cards
- MDI huddles
- Created a study with IRB approval and published in SCCM

Glucometer Cleaning



Culture

- Shared the why with the focus on the patient
- Rounding with team members and leaders
- Shared all rounding results with leader and team members



Leadership

- Leadership rounding
- Leadership accountability
- Executive leadership rounding
- IPE leadership rounding



Prevention

- K Card rounding
- Executive leadership rounding
- IPE rounding



Detection / Correction

- Corrected any dirty glucometers in real time
- Shared with local leader any dirty glucometers found in their space



Continuous Learning

- K card on MDI board
- Provided pareto charts and highlighted the highest risk areas
- Created sustainment plan
- Weekly sharing of results of auditing with leadership team

Improving Speak Up Culture



Culture

- Psychological Safety
- Thanking people for reporting
- Speak up award
- Rounding



Leadership

- Providing feedback in real time
- Making improvement evident
- Recognizing those that speak up
- Listening to understand



Prevention

- Rewarding near misses
- Making a Just Culture evident
- Psychological Safety



Detection / Correction

- Monitoring reporting rates
- Monitoring anonymous reporting rates
- Real time coaching



Continuous Learning

- Sharing Learning Together
- Using MDI huddles to track and trend
- Providing in the moment feedback
- Using process improvement to correct system issues identified
- Developing sustainment plans

Swarm



Tactic	Culture	Leadership	Prevention	Detection/ Correction	Continuous Learning	Is the intervention being used/performed?	Current Effectiveness of tactic	Barrier(s)
Fall Risk Score			x			yes	Intermediate	Performed Incorrectly, Incorrect fall risk tool selected
Bed Alarm				x		no	Intermediate	Forget, patient complaints
Grippy socks			x			no	Low	Patient removes, team member forgets to apply, incorrect sizes available
Arm Band			x			no	Low	Hard to find, forget to apply
Door Sign			x			yes	Low	Forget to apply, forget to remove when patient discharges

Swarm Instructions

- Evaluate all interventions in place for the problem you are solving
- Write down the intervention under the corresponding driver
- Identify drivers that are potentially missing interventions
- Evaluate the effectiveness of intervention
- Do people perform the intervention?
- Brainstorm ideas of interventions
- Be prepared to share with the group

Swarm Instructions

Tactic	Culture	Leadership	Prevention	Detection/ Correction	Continuous Learning	Is the intervention being used/performed?	Current Effectiveness of tactic	Barrier(s)

Discussion / Sharing

Questions?



thank you

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