Twenty questions you should ask now to adopt a high reliability organisation model for healthcare

A high reliability healthcare framework incorporates the principles of system-based thinking, continuous improvement based on impartial feedback, the implementation of mature risk and compliance functions and effective use of data to evolve a culture of collective achievement across the entire organisation. So, what action can you take right now?

It's complex and multifaceted but by going through this checklist you could identify some key areas that should be your priority focuses in your planning.

System-based thinking

- [ ] When incidents and near misses occur do you consider the direct and indirect sources of error across the whole system? Do you consider what controls failed and why? Do you critically assess whether a new intervention should be implemented and whether activities and controls can also be removed?
- [ ] Do you seek to reduce unwarranted variation in the system (eg. streamline control activities and standardise processes, forms, checklists etc)?
- [ ] Where emerging risks, incidents or near misses occur that result in changes to processes and controls, do you apply this change consistently and effectively across the system (the organisation, the health service, the health system)?

Effective use of data

- [ ] Are you using system-wide data in addition to clinical KPI results in a proactive way to identify risks including: clinical audit results; timely staff engagement and patient feedback results; HR data such as overtime, sick leave and agency usage etc?
- [ ] Do you leverage data to identify recurring incidents and predict emerging risks and trends across the system and proactively review?
- [ ] Do you leverage digital technology for audit and compliance activities to provide timely, accessible results to harness information and respond instantly?

Robust continuous improvement and feedback systems

- [ ] Do you track, audit and monitor the new controls and interventions for effectiveness?
- [ ] Do you capture your near misses and do you value and action this insight through sharing of lessons learned?
- [ ] Do you have robust and effective continuous improvement plans as well as remediation action plans?

Mature risk and compliance functions

- [ ] How confident is your Board that they have an integrated and complete assurance plan across the 'three lines of defence' (eg. clinical risk/ audit and clinical internal audit)?
- [ ] Do you have a robust and effective clinical governance framework with clearly defined accountabilities and responsibilities?
- [ ] Have you stratified and prioritised your key risks and controls by major clinical process areas and are your staff communicated to and trained on this? Do you seek to reduce variation, duplication and layering in processes and controls?
- [ ] Does your clinical audit plan align to the major clinical process areas and reinforce staff awareness of key and critical control activities at the frontline?
- [ ] Is your clinical audit plan agile enough to respond to emerging risks and strategic enough to get a balance between compliance, improvement and strategy?
- [ ] Are you 'everyday' accreditation ready? Do you look beyond accreditation, seeing it as the minimum foundational requirement and not the end goal?

Culture and collective achievement

- [ ] Do your staff feel comfortable speaking up for patient safety and are they respected and supported when they do?
- [ ] Are your patients and consumers encouraged and educated on being active participants in the safety of their care and speaking up?
- [ ] Is patient safety and quality paramount in your strategy and has this cascaded in a meaningful way from the board to the ward? Is it operationalised in such a way that all staff can articulate what this means for them, and how they bring it to life every day with their patients and residents and with each other?
- [ ] Have you considered setting ambitious safety targets to track and report, providing greater transparency? Do you hold each other to account and celebrate success together as a team?
- [ ] Do you encourage and reward proactive and positive patient safety behaviours and do you share the stories within your organisation?