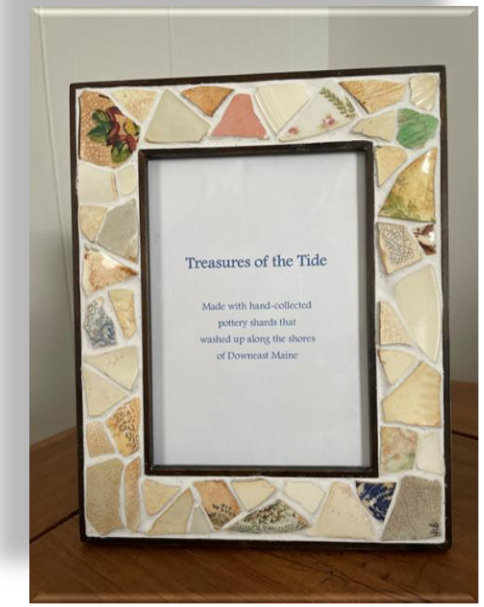
Tennessee Hospital Association

From Connecting the Dots to Tying the Knots: Elevating the Safety Culture to Drive Highly Reliable Results

Vikki Choate, DNP, MSN, RN, NEA-BC, CPHQ, CPPS, Certified Leapfrog Coach



© 2025 Huron Consulting Group Inc. and affiliates.

Safety of Care is ***Very*** Personal for Me

John had a stroke because of mis-diagnosis

Mom died because of hospital error

© 2025 Huron Consulting Group Inc. and affiliates.

Learning Objectives

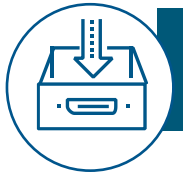
At the end of our time together today, you will be able to:

- **Recall the key tenets of a High Reliability Organization**
- **Describe one highly reliable leader attribute you plan to advance**
- **Implement or elevate one strategy to improve the safety culture of your organization**

© 2025 Huron Consulting Group Inc. and affiliates.

Our Agenda

Welcome and Connecting to Purpose



High Reliability & High Reliability Organizations

The Highly Reliable Leader

Elevating the Safety Culture

TENNESSEE HOSPITAL ASSOCIATION

© 2025 Huron Consulting Group Inc. and affiliates.

The Provocative Question on the Table: Is The Time for ‘Connecting the Dots Over?

Photo credit: LinkedIn

Photo credit: Getty Images/iStockphoto

© 2025 Huron Consulting Group Inc. and affiliates.

1

Let’s Begin by Connecting to Purpose.....

2

Let’s Ground

© 2023 Huron Consulting Group Inc. and affiliates.

The Past Few Years Have Been Hard!

© 2025 Huron Consulting Group Inc. and affiliates.

The 2025 Healthcare Quality and Safety Landscape is Challenging

Organizational safety culture is planted firmly in the center of the bullseye

What We're Hearing Reading About and Hearing in the Field
The **safety culture has weakened**; restoring it has proven challenging
Quality and safety **performance declined** as a result of the pandemic; **results are sluggish to restore**
Publicly reported quality dips have **increased stakeholder urgency** for improvement
Previous clinical & operational frameworks are less effective in the post-pandemic paradigm
Unavailable resources to resolve health disparities, holding patient safety hostage
Resources are insufficient to meet needs for improvement
COVID disruption lingers, continuing to burden limited, fatigued, and frustrated staff

© 2025 Huron Consulting Group Inc. and affiliates.

The Time to Elevate the Safety Culture of Healthcare is *NOW!*

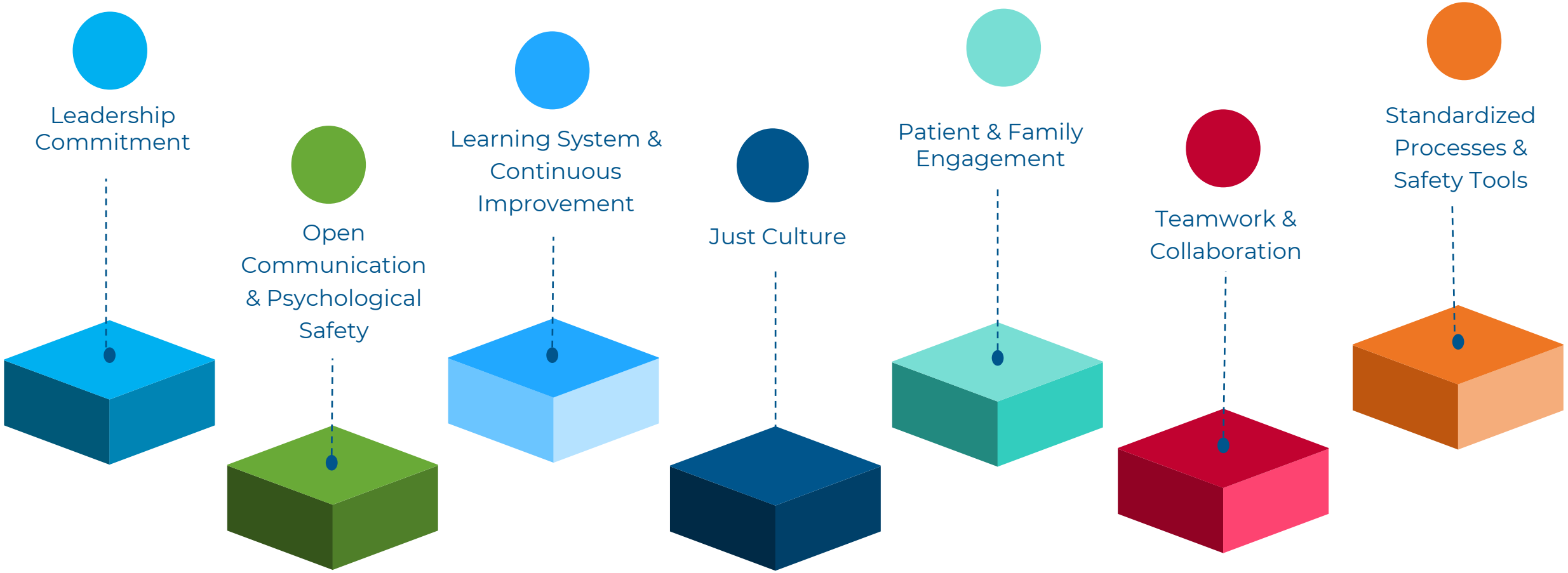
We have an *urgent need* to transform our approach:

- From **resilience to reliability**
- From **exceptions to excellence**
- From **independence to interdependence**
- From **obstacles to outcomes**
- From **burned out to buoyant**
- From **survive to thrive**
- From **unsafe to SAFE**

© 2025 Huron Consulting Group Inc. and affiliates.

A Strong Safety Culture Drives Highly Reliable Outcomes

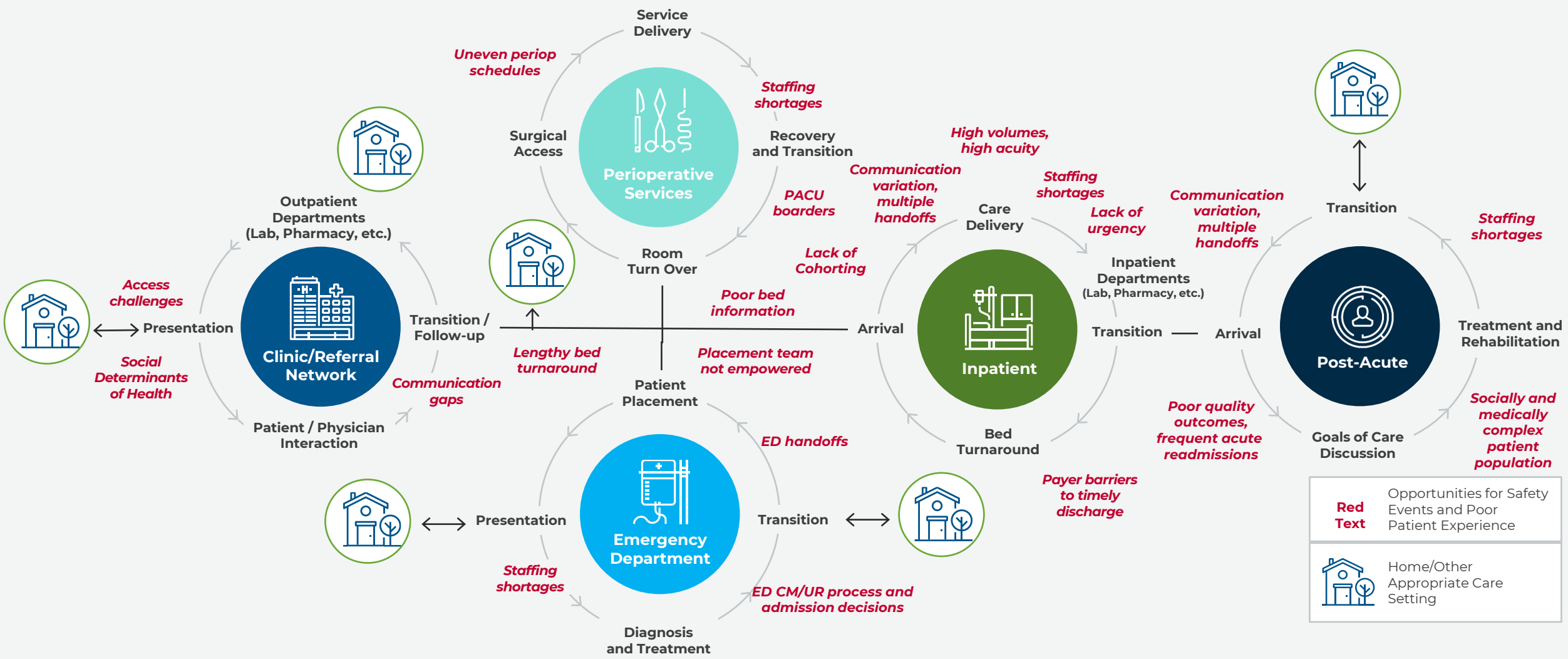
The result of highly reliable leadership, practices, processes, and people



© 2025 Huron Consulting Group Inc. and affiliates.

Because…..Every Patient, Every Interaction Matters

Health care delivery is complex and requires focus on consistent practices across the continuum and full optimization of the organization's safety culture. **Every patient interaction** is an opportunity to provide the safest, most efficient care and optimal patient experience possible.



“We must accept that human error is inevitable, and we must design around that fact.”

DONALD BERWICK

FORMER ADMINISTRATOR OF CMS AND PRESIDENT AND CEO OF THE INSTITUTE FOR HEALTHCARE IMPROVEMENT

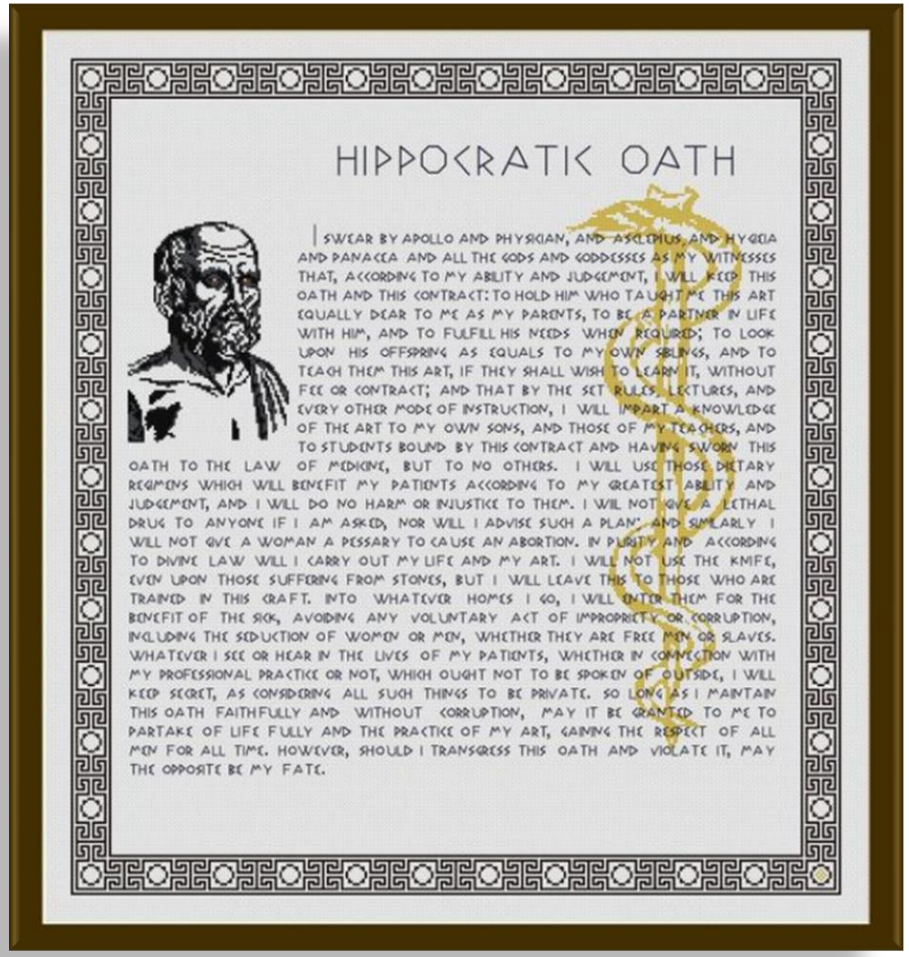
© 2023 Huron Consulting Group Inc. and affiliates.

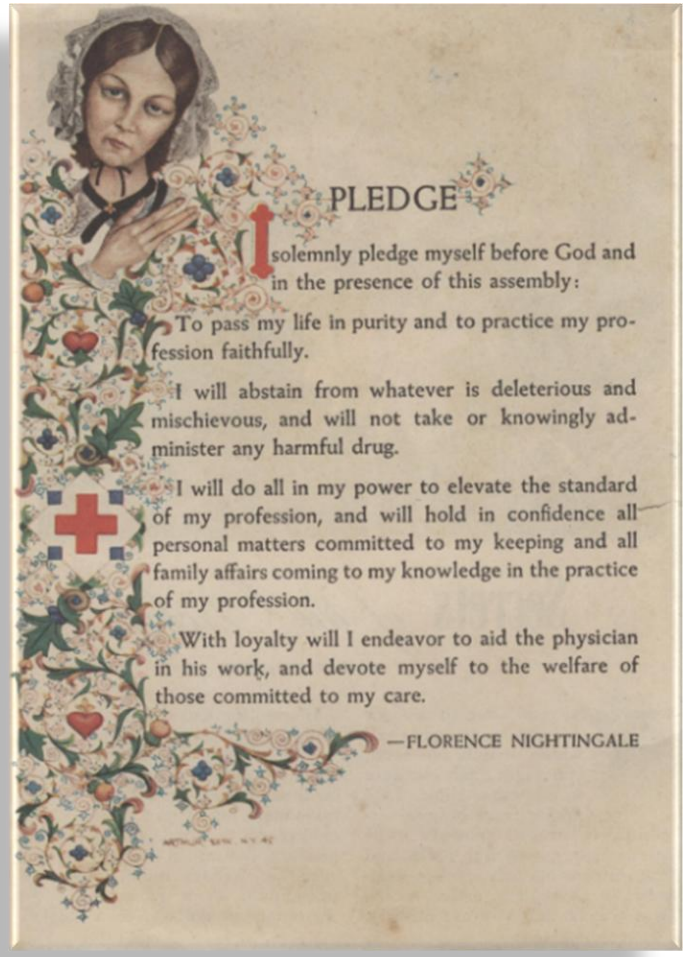
3

Let’s Explore High Reliability as a Safety Culture Strategy

© 2025 Huron Consulting Group Inc. and affiliates.

The *REAL* Beginnings of Safety and Safety Culture





Hippocrates, 5th to 3rd centuries BC

Lystra Gretter & Farrand Training School Grace for Nurses, 1893

© 2025 Huron Consulting Group Inc. and affiliates.

The More Modern History of High Reliability

Normal Accident Theory | "Big accidents almost always have very small beginnings"

Source: Perrow, C. (1984). *Normal Accidents: Living with high-risk technologies*. Basic Books.

© 2025 Huron Consulting Group Inc. and affiliates.

Defining High Reliability

High reliability in health care refers to an organization's consistent ability to deliver safe, high-quality care over time, even in complex and high-risk environments by minimizing error, preventing harm, and maintaining excellence through:

- **A strong safety culture**
- Continuous improvement
- Standardized processes

© 2025 Huron Consulting Group Inc. and affiliates.

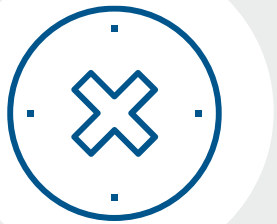
The Language of High Reliability

Examples of terms commonly used in high reliability science

1. Zero Harm
2. Operational Excellence
3. Safety Culture
4. Situational Awareness
5. Collective Mindfulness
6. Psychological Safety
7. Normalization of Deviance
8. Human Factors
9. Systems Thinking
10. Process Engineering
11. Learning Systems
12. Innovation
13. Just Culture
14. Lean, Six Sigma
15. Improvement Scholarship
16. Process Integrity

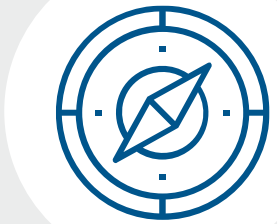
© 2025 Huron Consulting Group Inc. and affiliates.

Characteristics of High Reliability Organizations



1. PREOCCUPATION WITH FAILURE

- Constant focus on what could go wrong
- Relentless commitment to prevent mistakes
- Recognize signs that a threat may be developing
- Constant mindfulness of the situation at hand



2. COMMITMENT TO RESILIANCE

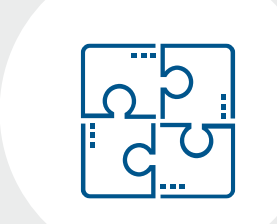
- Recognize that despite best efforts, errors will occur in this very complex environment
- Identify & contain issues to prevent additional disruption
- Recover quickly to avoid derailment

3. SENSITIVITY TO OPERATIONS

- Recognize challenges of running a complex health system
- Evaluate effect of processes on system
- Support awareness of what is working and not working
- Deepen awareness through improved communication

4. DEFERENCE TO EXPERTISE

- Value experience
- Avoid making decisions based on power
- Give decision making authority to the person(s) identified to have the greatest expertise to manage the situation



5. RELUNTANCE TO SIMPLIFY

- Understand that threats to safety can be complex
- Accept additional steps/work to ensure safety
- Refuse to simplify reasons for errors or solutions to problems

Source: Weick, K., Sutcliffe, K. (2007). *Managing the Unexpected: Resilient Performance in the Age of Uncertainty*. Jossey-Bass.

© 2025 Huron Consulting Group Inc. and affiliates.

Examples of Applying High Reliability Organizing to Daily Operations to Improve Safety and Safety Culture

1. PREOCCUPATION WITH FAILURE

- Safety-focused shift & daily safety huddles
- Bundle adherence & other audits
- Human factors
- Learning from near misses
- Hourly Rounding
- Bedside Shift Report
- Readmission risk assessments
- Sepsis recognition & rescue

2. COMMITMENT TO RESILIANCE

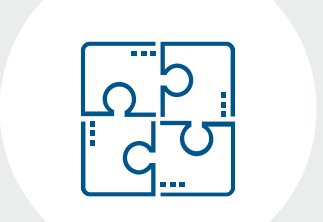
- Post-safety event huddles/swarms
- Second victim support
- Just Culture approach to root cause determinations
- Broadcast learnings from errors and near misses to prevent recurrence

3. SENSITIVITY TO OPERATIONS

- Cascade safety huddle info widely
- Schedule check-ins on system stressed days
- Round for safety and experience
- Culture of Safety Survey action plans
- Patient and Family Advisory Councils

4. DEFERENCE TO EXPERTISE

- Shared Governance
- Unit-based Practice Councils
- Support professional certifications
- Engagement of frontline staff in recommendations and decision-making



5. RELUNTANCE TO SIMPLIFY

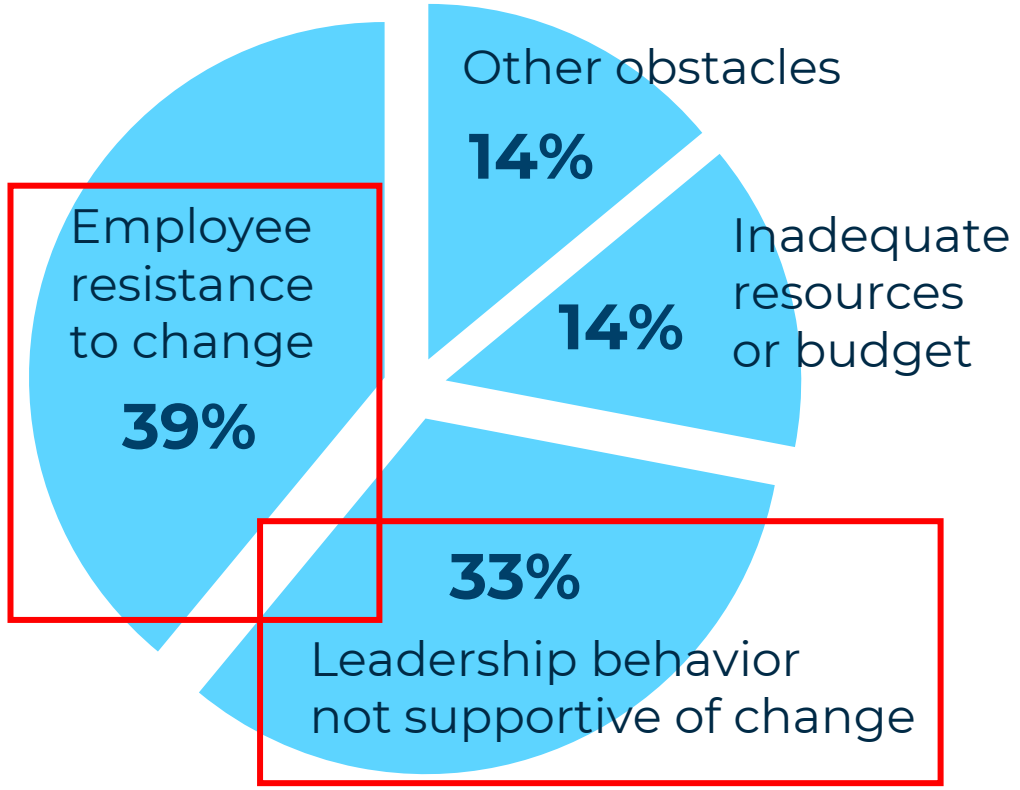
- No short cuts
- No workarounds
- Design process redundancies (systems engineering)
- Resist simple explanations for error; RCA 5 Whys

© 2025 Huron Consulting Group Inc. and affiliates.

But….. High Reliability is Hard and Sustainability, Elusive

Across healthcare, over 70% of change and transformation initiatives fail.

Understanding why strategies fail is important to avoiding pitfalls on the road to high reliability.



39 + 33 = **72%**

Source: McKinsey. (2015). *Changing change management*.

© 2025 Huron Consulting Group Inc. and affiliates.

What's in the Way of High Reliability?

Barriers to High Reliability

1. Short staffed, tired staff, agency reliance
2. Reluctance to hold staff accountable out of fear
3. Culture doesn't support speaking up
4. Tolerance of undesired variation
5. Competing priorities; continual change

© 2025 Huron Consulting Group Inc. and affiliates.

Making the Mindset and Operational Shifts: Advancing from Hardwired > Highly Reliable

Hardwired vs. Highly Reliable

- Goal is about 90% of the time
- Driver is **compliance**

- Goal is every time
- Driver is **commitment**

© 2025 Huron Consulting Group Inc. and affiliates.

The Ugly Truth? **We're Far from Always**

Despite our most noble intentions.....

- 2000 | **44,000 to 98,000** people died in hospitals every year as a result of preventable medical error[1]
- 2008 | **27%** of Medicare patients experienced preventable harm[2]
- 2013 | **440,000** deaths caused by preventable harm; **6 million** healthcare-associated injuries per year[3]
- 2022 | **25%** of Medicare beneficiaries experienced harm in October 2018[4]

Source 1: Kohn LT, Corrigan, JM, Donaldson, MS. (2000) Institute of Medicine. To err is human: Building a safety health system
Source 2: Office of Inspector General. (2010) Adverse events in hospitals: A quarter of Medicare patients experienced harm in October 2018
Source 3: James, JT. (2013) Journal of Patient Safety. A new, evidence-based estimate of patient harms associated with hospital care
Source 4: Office of Inspector General. (2022). Adverse events in hospitals: A quarter of Medicare patients experienced harm in October 2018

© 2025 Huron Consulting Group Inc. and affiliates.

Healthcare Has a Knowing/Doing Gap

Hungarian Physician Ignaz Semmelweis | July 1818 – August 1865

Study published in 1847 confirmed that the incidence of puerperal fever (healthcare acquired infection) could be drastically reduced by the implementation of hand washing between obstetrical patients.

In 2020, CDC reported:

- Healthcare workers **wash hands 50%** of the time
- **1 in 3 patients** acquire infection in the hospital

The WHO reports:

- Hand hygiene **compliance needs to be 90%** or greater to prevent health-care acquired infections
- **9% compliance** washing hands after using the toilet (world-wide)

(1818–1865)

© 2025 Huron Consulting Group Inc. and affiliates.

4

Let’s Explore Highly Reliable Leadership

© 2025 Huron Consulting Group Inc. and affiliates.

Attributes of Highly Reliable Leaders

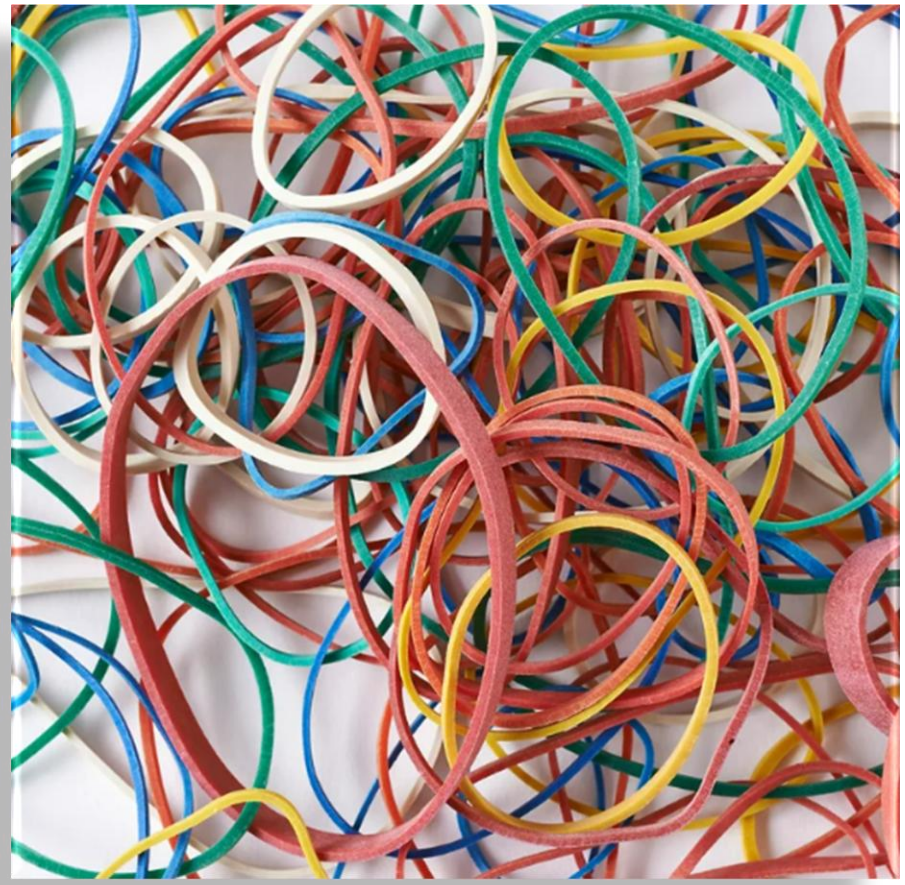
Common characteristics, skills, and disciplines

Have	Foster	Demonstrate
Vision	Resilience	Adaptability
Stakeholder Focus	Fairness/Justice	Ethical Decision Making
Integrity	Dependability	Consistency
Empathy	Psychological Safety	Team building
Decisiveness	Accountability	Priority Management
Self-Awareness	Transparency	Ability to Influence
People Orientation	Interaction	Intentional Communication

© 2025 Huron Consulting Group Inc. and affiliates.

Attributes of Highly Reliable Leaders

1) RESILIENCE *| Knowing when to use rubber bands; knowing when the job calls for rope*



Source: snopes.com

Source: buyrope.com

© 2025 Huron Consulting Group Inc. and affiliates.

The Tale of the Hoodies and the Hair Pins

Rubber bands or rope?

Source: Etsy

Source: Bling3t

© 2025 Huron Consulting Group Inc. and affiliates.

Attributes of Highly Reliable Leaders

***2) PSYCHOLOGICAL SAFETY** | Creating a thriving workplace environment*

High	**Comfort Zone**	**Learning Zone**
Low	**Apathy Zone**	**Anxiety Zone**
	Low	High

© 2025 Huron Consulting Group Inc. and affiliates.

Attributes of Highly Reliable Leaders

3) ABILITY TO INFLUENCE *| Engaging to activate and retain (leader standard work)*

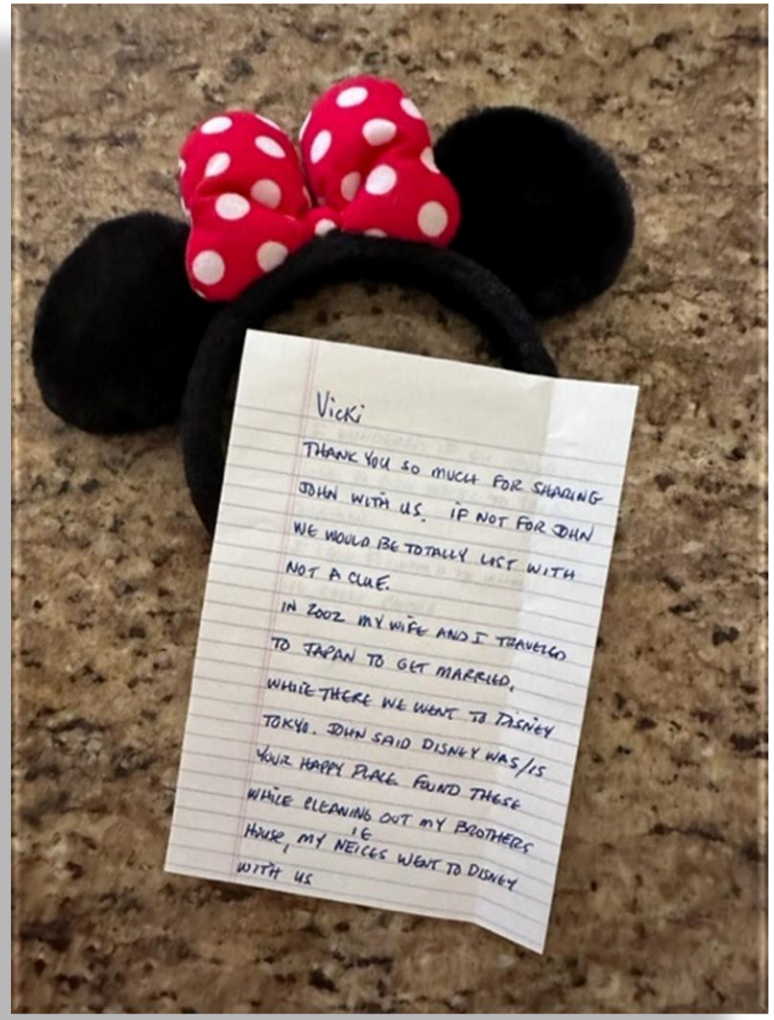
- **Re-recruit daily**
- **Customize your rounding** for desired influence
  - Retain concepts; they're highly evidence-based:
    - Personal relationship investment
    - Capture wins
    - Secure recognition opportunities
    - Identifying barriers to peak performance
    - Address tough questions
  - Distinguish between **social and intentional communication**

Source: Getty Images

© 2025 Huron Consulting Group Inc. and affiliates.

Attributes of Highly Reliable Leaders

4. ABILITY TO INFLUENCE *| Provide specific and meaningful recognition*



© 2025 Huron Consulting Group Inc. and affiliates.

Attributes of Highly Reliable Leaders

4: ABILITY TO INFLUENCE *| Round to improve safety culture*

Tools and Equipment

- Do you have what you need to keep you, our team, and our patients safe?
- What barriers are getting in the way of providing the safest care we can?

Concern and Care

- How are you?
  (Make a Personal Connection)

What is working well?

- What's working well with regards to keeping our patients and our team safe?

Systems to Improve

- What can we do better to improve patient and team member safety?
- What can we do better to improve our safety culture?

People to Recognize

- Who can I recognize for providing exceptional and safe care to our patients?
- Who can I recognize for supporting the safety of our team?

© 2025 Huron Consulting Group Inc. and affiliates.

Attributes of Highly Reliable Leaders

5: STAKEHOLDER FOCUS *| …which is really all about caring*

"One of the most important things I do every day is make sure my team – my ***amazing*** team – knows how much I love and support them in all ways…**always**….

…It's the little things, ya know?"

Source: Nurse Manager, Providence RI

© 2025 Huron Consulting Group Inc. and affiliates.

5

Let’s Talk Optimizing Your Safety Culture!

© 2025 Huron Consulting Group Inc. and affiliates.

1: Examine and Adjust How Safety is Prioritized

Embed safety everywhere to elevate organizational awareness

- **Open all meetings** with a 1-2 minute **“safety story”**
- **Reprioritize pillars** to place people first, follow with quality, and end with finance
- Begin all communication reinforcing the **organization’s commitment to safety**
- Bring safety into employee and physician **rounding conversations**
- Open key employee/provider **interaction opportunities with safety culture message**
- Invite Board members to attend an upcoming Daily Safety Huddle!

Source: Citizens Memorial Healthcare

© 2025 Huron Consulting Group Inc. and affiliates.

2: Ensure Leaders Have Cultural Maturation Skills

Leader development is a non-negotiable; #learntolead

- Provide on-going **leader development** on topics such as:
  - Leading through change and transformation
  - Leader's role in promoting psychological safety
  - Effective communication and story-telling
  - SMART action plan development and execution
  - Difficult conversations
- **Include physician leaders**
- Design curriculum informed by **leader skill needs assessment**
- Establish application expectations, coach skill development, and **audit for commitment and execution**

Source: depositphotos.com/stock-photos/checklists.html

© 2025 Huron Consulting Group Inc. and affiliates.

3: Evaluate Effectiveness of Safety Culture Strategies

Post-pandemic: it's a critical time to look 'under the hood'

- Conduct through validation of the effectiveness of the influencers of your safety culture; examples include:
  - **Daily Safety Huddles** (tiered, executive, unit/department)
  - **Safety event reporting** and management
  - RCA and FMEA processes' **focus on process vs. people**
  - **Fair and just culture approach** to human factors-related erro
  - **Leader rounding** and employee/provider engagement practices
  - Use of data to **educate and activate the workforce**
  - Lingering **COVID-related shortcuts** and workarounds

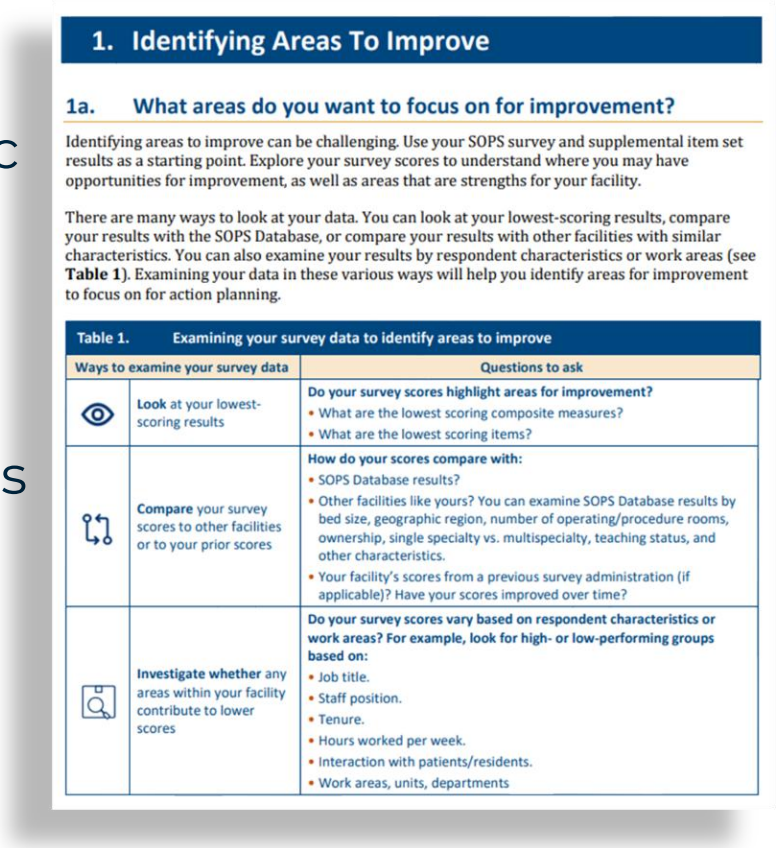
Source: depositphotos.com/stock-photos/checklists.html

© 2025 Huron Consulting Group Inc. and affiliates.

4: Write Results-Producing Safety Culture Survey Action Plans

Establish action and accountability

- Action plans must be **SMART**
- Develop **system, facility, and unit/department** specific action plans
- **Include staff in selection** of safety culture items to focus on
- **Engage staff in developing** action plans for focus items
- Establish organizational and **leader standard work** for keeping action plans alive and optical
- Use **quarterly pulse process** to action plans' ability to move the needle; modify if necessary



1. Identifying Areas To Improve

1a. What areas do you want to focus on for improvement?

Identifying areas to improve can be challenging. Use your SOPS survey and supplemental item set results as a starting point. Explore your survey scores to understand where you may have opportunities for improvement, as well as areas that are strengths for your facility.

There are many ways to look at your data. You can look at your lowest-scoring results, compare your results with the SOPS Database, or compare your results with other facilities with similar characteristics. You can also examine your results by respondent characteristics or work areas (see **Table 1**). Examining your data in these various ways will help you identify areas for improvement to focus on for action planning.

Table 1. Examining your survey data to identify areas to improve

Ways to examine your survey data		Questions to ask
	Look at your lowest-scoring results	**Do your survey scores highlight areas for improvement?** • What are the lowest scoring composite measures? • What are the lowest scoring items?
	Compare your survey scores to other facilities or to your prior scores	**How do your scores compare with:** • SOPS Database results? • Other facilities like yours? You can examine SOPS Database results by bed size, geographic region, number of operating/procedure rooms, ownership, single specialty vs. multispecialty, teaching status, and other characteristics. • Your facility's scores from a previous survey administration (if applicable)? Have your scores improved over time?
	Investigate whether any areas within your facility contribute to lower scores	**Do your survey scores vary based on respondent characteristics or work areas? For example, look for high- or low-performing groups based on:** • Job title. • Staff position. • Tenure. • Hours worked per week. • Interaction with patients/residents. • Work areas, units, departments

Source: ahrq.gov/sites/default/files/WYSIWYG/sops/sops-action-planning-tool.pdf

© 2025 Huron Consulting Group Inc. and affiliates.

Attributes of Highly Reliable Leaders

5: STAKEHOLDER FOCUS *| Which is really all about caring*

"One of the most important things I do every day is make sure my team – my ***amazing*** team – knows how much I love and support them in all ways…**always**….

…It's the little things, ya know?"

Source: Nurse Manager, Providence RI

© 2025 Huron Consulting Group Inc. and affiliates.

Let’s Keep the Conversation Going!

Vikki Choate, DNP, MSN, RN,NEA-BC, CPHQ, CPPS, Certified Leapfrog Coach
Principal | Quality, Safety, and High Reliability
vchoate@hcg.com | 207.607.2218

© 2025 Huron Consulting Group Inc. and affiliates.