ORGANIZATIONAL SELF-ASSESSMENT: HIGH RELIABILITY JOURNEY

	Reactive	Proactive: Managing the Expected	Generative: Managing the Unexpected
1	Adjustments in patient care (e.g., medication dosing, ventilator weaning, urinary catheter removal) are typically by physician order.	Standard approaches are in use for some care processes, such as: standard order sets and standing orders, care pathways, etc. A few clinical protocols managed by non-physician clinical staff are used.	Clinical protocols for patient care adjustments by qualified clinical professionals (NP,RN,RPh,RT,PT, etc.) are common throughout the organization and well supported by medical staff.
2	Team huddles are rare or occur on an ad hoc basis, typically led by a manager or supervisor.	Huddles are held for some high-risk procedures or situations. Structure is informal with limited tools, not standard. Focus is on prevention or to debrief after adverse event or situation.	Structured huddles are held routinely for specified areas and procedures using standard methods and tools. Post-huddles are conducted even when all goes as planned. Huddles are led by team members with expectation for all to speak up.
3	Few standard care processes are used outside of emergency situations, such as standing orders for cardiopulmonary arrest or in critical care.	Standard care processes are used for critical processes. Clinicians select whether standard processes are used for their patients and sometimes have their own (i.e., standing order sets or individual kits/trays). Variations from standards are not routinely tracked.	Standardized clinical processes are based on clinical evidence. Standard response plans are in place for known unexpected conditions. Staff can identify the need for alternate approaches and are expected to report for learning.
4	Design of new processes is by managers. Redesign of current processes typically happens in response to an event or situation and is handled by managers. Improvement generally focuses on policies and training and education only.	Design of new processes and redesign of current processes includes front line staff in design work. Processes are assessed for re-design opportunities on a periodic basis.	Design of new processes and redesign of current processes are driven by front line staff and patients and families are included in design work. Expected and recurring unexpected conditions are identified and used to design.

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5	Processes are changed in response to events and situations, or as identified by management. Data may be collected to monitor changed processes for lack of compliance.	Changes to processes are sometimes tested prior to implementation. Emphasis in design is to avoid failure at the process and step level. Data may be collected to monitor changed processes for variation and used to refine the process.	Prior to changing a process, prospective analysis (such as FMEA) and testing occurs to determine unanticipated consequences and assess potential impact of changes. Front line staff are key participants in analysis and testing. Learning from new unexpected conditions and staff solutions are used for redesign.
6	Root causes analysis methods are used only after serious adverse events (e.g., sentinel events, permanent harm, death).	Root causes analysis methods are used for many adverse events, not only serious ones, and to study some process failures even if no adverse event has occurred.	Root causes analysis methods are used to study processes and systems that are working well without reported failures or adverse events.
7	Data are reviewed following an adverse event or situation to determine whether policy and procedure was followed.	Data for critical processes and outcomes are routinely analyzed for variation and used to determine where variation can be reduced by process redesign.	Variation that cannot be controlled is identified and mitigation strategies are developed to avoid disruption of critical services and adverse events.
8	Structured systems are in place for responding to events and/or situations, such as Rapid Response Teams. Response systems are activated by front line staff when event or situation occurs.	Criteria are used to identify potential for events and situations before they occur, such as Early Warning Scores. Response systems can be initiated by anyone, including patients and families, for any reason.	The organization regularly studies and collects information about events and situations that have occurred in other organizations to assess response readiness.
9	Drills or simulations are rarely or never conducted, or occur only after an event or situation occurs.	Drills or simulations are conducted periodically on events or situations known to occur in our organization (e.g., cardiac arrests).	There is regular review and discussion about events that have occurred in other places and drills or simulations are routinely conducted on events or situations that have never occurred in our organization.