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5 Traits of High Reliability Organizations: How to Hardwire Each in Your Organization

Written by Molly Gamble (Twitter | Google+) | April 29, 2013

Can healthcare be more like the airline industry? Quint Studer, founder and Chairman of the Board at Studer Group, says yes — and that's good news for hospitals and patients alike.

In early 2013, the Aviation Safety Network said 2012 was "the safest year for air travel since 1945." The year saw 23 crashes occur worldwide, resulting in 475 air fatalities and 36 ground fatalities — or one fatal crash per every 2.5 million flights. ASN further reported that these numbers represent a tremendous improvement over the 10-year average of 34 fatal crashes and 773 deaths.

ASN President Harro Ranter was quoted as saying, "Since 1997 the average number of airliner accidents has shown a steady and persistent decline, probably for a great deal thanks to the continuing safety-driven efforts by international aviation organizations … and the aviation industry.[1]"

Much like the key players in the airline industry, the healthcare industry does complex, high-stakes work where mistakes can equal great harm, points Mr. Studer. That's why so many hospitals are embracing the values of high-reliability organizations and occupations like air traffic control towers, nuclear power plants, wildlife fire fighters and astronauts. The paradigm works remarkably well in the promotion of patient safety and efficient healthcare delivery.

"High reliability organizations are organizations with systems in place that make them exceptionally consistent in accomplishing their goals and avoiding potentially catastrophic errors," says Mr. Studer.

Throughout his work with hospitals and health systems, Mr. Studer has found a link between high reliability organizations and hardwiring certain tools, behaviors and techniques within the organization's culture.

Here, he expands on the five traits of high reliability organizations: sensitivity to operations, reluctance to oversimplify the reasons for problems, preoccupation with failure, deference to expertise and resilience. He also shares hardwiring strategies that can help hospitals and health systems develop and sustain each of those traits.

1. High reliability organizations are sensitive to operations. Leaders and staff need to be constantly aware of how processes and systems affect the organization. In high reliability organizations, each employee pays close attention to operations and maintains awareness as to what is or isn't working. There are no assumptions. This steady concentration on processes leads to observations that inform decision-making and new operational initiatives.

How to hardwire this value
Get more transparent. Mr. Studer says hospitals and health systems can hardwire attentiveness into

their organizations by being more transparent. The more employees know, the more they will pay attention. But transparency is a relatively novel value in the healthcare industry, and to promote it, hospitals may have to challenge themselves.

"When I was president of a hospital, every day we sent out the number of hospital-acquired pressure ulcers," says Mr. Studer. "That created constant awareness among staff."

The point is simple: leaders can drive more organizational awareness through improved communication and data sharing, whether the data being shared is a patient safety metric or perception of care result.

Use rounding to drive outcomes. There is no substitute for observing operations firsthand. Rounding can help leaders develop a more textured understanding of hospital processes. Essentially, hospital leaders take an hour or so to attentively watch processes and talk with employees and supervisors. Rounding promotes open, purposeful communication. If done correctly, it also unveils which processes are working and which ones are burdening employees or interfering with patient care, says Mr. Studer. Leaders should make rounds with a sense of purpose and an eagerness to identify operational problems.

Don't make assumptions. As leaders make their rounds, Mr. Studer says leaders should ask questions about processes that are in place. For instance: "Do you know of anything we do here that could be harmful to a patient? Have you seen anything that concerns you?" Staff may not automatically voice these issues to leaders because they think their concerns have already been noted. Hospital leaders should hold proactive discussions to ensure employees' concerns are heard.

2. High reliability organizations are reluctant to accept "simple" explanations for problems. Broad, rational excuses can be attractive when processes don't work well. But high reliability organizations resist simplifications. While it is beneficial to simplify some work processes, high reliability organizations recognize the risks of painting with broad strokes and failing to dig deeply enough to find the real source of a particular problem.

"Organizations that are not having success want to jump into simple explanations as to why," says Mr. Studer. "They may point to a simple reason like poor communication, to staffing shortages or limited resources. If they dig deeper they may find an explanation underlying the more surface one."

High reliability organizations do identify potential reasons for poor performance, but they don't stop there — they continue to probe further. They ask more questions. They keep digging until find the specific source of the problem.

For example, Mr. Studer was recently at a hospital where a nurse told him the nursing unit was short-staffed. When he asked the nurse why she thought the unit was short-staffed, she said she was waiting for a transporter to pick up one of her patients, but her call light was also on. As a result, she was conflicted between her responsibilities and felt short-staffed — even though that was not the case.

"The real issue was coordination of transports," says Mr. Studer. "That was the problem that needed to be addressed."

How to hardwire this value

As you examine data and metrics, be willing to challenge long-held beliefs. When they round, leaders

constantly look at data, benchmarks and other performance metrics. But to prevent simplification, leaders should constantly seek information that challenges their current beliefs as to why problems exist.

Mr. Studer visited one hospital at which employees attributed low patient experience scores to the high volume of patients admitted from the emergency department. Initially, he said this reason seemed sound and logical. It could quickly cement itself as a fundamental belief throughout the organization, making employees less inclined to alter their behavior to improve patient experience scores.

But Mr. Studer probed the reason further. Upon closer inspection, he found the opposite to be true: People admitted through the ED were actually more satisfied than direct admissions. When patients were admitted through the ED, they were more likely to be prepared for longer wait times or other operational issues. But patients admitted through a direct referral from their physicians expected a swift and seamless admission process, only to be disappointed when such did not occur.

The lesson? To become high reliability organizations, hospitals need to dig into their metrics, compare information and question explanations that may seem reasonable or obvious, because the very opposite may be true.

3. High reliability organizations have a preoccupation with failure. Every employee at every level in a high reliability organization is encouraged to think of ways their work processes might break down. This sense of shared attentiveness is constant. It is applicable to small inefficiencies and major failures, including medical errors. Employees are encouraged to share their concerns for potential failures, which can help create best practices across departments.

High reliability organizations de-stigmatize failure. Medical errors that are detected and corrected before harming patients are called "near-misses," and Mr. Studer says high reliability organizations treat these events differently from other hospitals. They encourage employees to come forward with near-misses and they focus on which processes and safeguards work best.

"High reliability organizations might look at near misses and say, 'The good news is we have some effective safeguards in place," says Mr. Studer. "Let's not consider it a failure."

How to hardwire this value

Identify what is working correctly. When a process is implemented incorrectly in a high reliability organization, leaders don't simply give up. Instead, they find another place within the organization where that same process is running smoothly.

"People are better at diagnosing problems when they find some success," says Mr. Studer. "They might say, 'How can they do it in this department, but not in this one?' Try to take away excuses by finding places where the process has already been carried out successfully."

Mr. Studer visited an organization that had low scores for every HCAHPS measure except for one: pain management. When he asked the chief nursing executive how pain management was so well controlled, she described a hospital-wide best practice that every employee was trained to follow. The hospital recognized and rewarded employees for following this process and conducted regular follow-ups to ensure it was implemented. In the end, the best practice is what drove the satisfactory HCAHPS score.

"They already had a system in place," says Mr. Studer. "I said, 'Just do that with the other HCAHPS metrics. You already have elements of success.'"

Leaders at high reliability organizations don't quit process improvements after just a few months, adds Mr. Studer. Rather, they lead employees to see that success is attainable and borrow best practices from other successful operations.

4. High reliability organizations defer to expertise. Leaders at high reliability organizations listen to people who have the most developed knowledge of the task at hand. Sometimes, those individuals might not have the most seniority, but they are still encouraged to voice their concerns, ideas and input — regardless of hierarchy.

If leaders and supervisors don't listen to staff about processes and operations within the hospital, it is practically impossible for the organization to develop a culture of high reliability.

"The worst thing a leader can say when someone provides input is, 'I already know that,'" says Mr. Studer. "Then people stop telling you things." Rather, high reliability organizations work to find ways in which each employee's input can make them better.

How to hardwire this value

Redefine "meetings." The best place for conversations between leaders and staff is in the work area — not in conference rooms or meetings, says Mr. Studer. He recommends organizations adopt "no-meeting time zones" so managers can make rounds and receive feedback from employees, supervisors and other staff members.

Mr. Studer says one hospital CEO asked members of his management team to block off numerous hours for a day-long meeting. Really, the "lengthy meeting" took only a few hours during the morning. In the afternoon, the CEO asked managers to make rounds and talk to employees.

"He said, 'I know you have time, because I just freed up the afternoon you had booked for this meeting,'" says Mr. Studer.

By observing processes and meeting with employees in their actual work space, leaders can more easily defer to employees' expertise and customs.

Ask about prior experiences. Most people who work in healthcare have prior experience with another healthcare organization. Hospital leaders should not let this vast source of expertise go untapped.

"The best place to get a fresh pair of eyes is from new staff," says Mr. Studer. "In healthcare, organizations hire consultants and pay them thousands of dollars to tell them what staff could tell them for free."

Mr. Studer recommends managers hold 30- and 90-day reviews with new employees. In those meetings, managers or supervisors should ask the employee this question: "Based on your prior work experience, what are some ideas you have to improve operations here?" The answers might be surprisingly simple, but lead to remarkably effective processes.

Mr. Studer remembers when one employee's recollection of a seemingly small detail made a big

difference. An employee came to a new hospital and told her managers about a hospital-wide custom at her previous place of work. If a patient was prone to falls, nurses put a yellow blanket on the patient's bed. The nurses explained to the patient and patient's family why that person had a yellow blanket on the bed, and it also became a well-known symbol among staff.

"Any hospital employee walking by the room could glance in, see the blanket and know that person was prone to falls," says Mr. Studer.

The hospital took this idea and implemented it as well, enhancing its culture of safety through a simple yet effective technique borrowed from an employee's previous workplace.

5. High reliability organizations are resilient. This trait could also be called relentlessness, says Mr. Studer. Leaders at high reliability organizations stay the course. They are prepared in how to respond to failures and continually find new solutions. They might improvise more, or quickly develop new ways to respond to unexpected events. High reliability organizations might experience numerous failures, but it is their resilience and swift problem solving that prevents catastrophes.

How to hardwire this value:
Use better evaluation tools. Effective leadership evaluations are key to the development and maintenance of a high reliability organization. Mr. Studer says organizations that do not set specific and measurable goals, and do not change the way leaders are evaluated on those goals, do not sustain results. High reliability organizations hardwire evidence-based leadership evaluation tools, such as report cards and 90-day action plans, into their organizations and prioritize goals. This way, leaders are constantly challenging and improving upon themselves and how they respond to problems. This will ultimately drive a shared sense of resilience throughout the organization.

Emphasize skill development. The Studer Group promotes skill development on a routine basis with its 90-day action plan. Under this program, managers and leaders complete a leadership self-assessment scorecard. They then select one competency to work on for the next 90 days, and develop and action plan with their supervisor or senior leader to master this competency. The skill might be listening, providing negative feedback, mentoring, delegating tasks or a range of other leadership topics.

The manager and senior leader create a 90-day plan to identify incremental tasks and targets to support the development of this skill. Mr. Studer says 90 days is an appropriate amount of time, as people can authentically develop skills in this timeframe and are less likely to merely fake them at the end of month three.

"It keeps their eye on the ball," he explains.

Help people reconnect to the "why" behind what you ask them to do. Above all else, employees at high reliability organizations remember their purpose. They do worthwhile work and feel as though they can make a difference within their organizations. Each and every employee believes he or she has the ability to better the organization, whether it's reporting a safety concern to a leader during rounding, proposing an idea to reduce patient falls, or working with team members to develop a new skill set.

"By tying organizational results back to their purpose and worthwhile work, organizations are inspired to achieve greater results," says Mr. Studer.

1. Aviation Safety Network (ASN). 2013. "2012 Exceptionally Safe Year for Aviation."
ASN News. Published January 1. http://news.aviation-safety.net/2013/01/01/ 2012-exceptionally-safe-year-for-aviation/

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