Emily's Musings: Thoughts from UHN's Patient Safety Officer

High Reliability Organizations

Health care workers enter this field because they inherently want to help patients achieve safe and effective care. However in our complex environment, we may not always be aware of the latest strategies for achieving this. One of my goals as UHN's Patient Safety Officer is to share the concepts, principles and best practices related to patient safety so that each person in our organization has the chance to understand and apply these in the course of their own work. Over the last few weeks, a new language has entered our consciousness. The term HRO has been used in emails from Dr. Pisters, at Senior Management Team discussions, Medical Advisory Committee meetings and various site forums.

But what does this term actually mean?

A high reliability organization (or HRO) refers to organizations, such as those in aviation, hazardous chemicals, and nuclear power industries, that have succeeded in avoiding accidents despite typically operating in a risky and complex environment. HROs design their systems to avoid known sources of failure. At the same time, these companies anticipate that errors and unexpected systems failures will happen regardless of how well they were initially designed. Therefore, individuals working in these organizations are constantly on the look-out for potential areas of risk and respond in a timely manner as soon as these situations are detected. In this way, HROs strive to reliably achieve zero percent error.

How reliable is the healthcare sector?

In comparison, healthcare "reliability" is often described as "chaotic" or in other words, experiencing greater than 20% error in any process. Moving towards high reliability means:

- making patient safety everyone's priority
- simplifying the number of steps in any process to decrease the potential for error
- standardizing the way we do things so that all team members know what is expected and can easily detect when the unexpected occurs
- empowering staff so that they can act to resolve any situations that put a patient's safety at risk
- avoiding complacency and the belief that "errors cannot happen here"
- aiming to reduce preventable patient harm to zero

Do you want to learn more about this topic?

Here are two great reads to check out:

- John J. Nance's novel: *Why Hospitals Should Fly: The Ultimate Flight Plan to Patient Safety and Quality Care*
- Mark Chassin and Jerod Loeb's article: *The Ongoing Quality Improvement Journey; Next Stop, High Reliability* which is available through the UHN Virtual Library (Health Affairs, 30, no.4 (2011):559-568.