Level 3 Reliability: Design of High Reliability Organizations
When these tactics are used expect <5 failures out of 1,000 opportunities or 99% reliability

Tactic | Description | Example | Accessibility
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Making the System Visible | Allow for a predetermined course of action when a specific condition is identified | PICU board displayed on electronic patient boards | High risk or time sensitive scenarios with multiple action options
Clear and unambiguous communication | The sender has a working knowledge that the receiver has received the correct information | Write down and read back of verbal orders | Situations requiring accurate/complete communication to deliver desired outcomes
Preoccupation with Failure | Every employee at every level of the organization is thinking of what could go wrong | Identifying key pathways to an individual patient’s clinical deterioration and developing specific assessment and potential intervention plans. Failure Modes and Effects Analysis/Proactive Risk Assessment Studying work flow processes and identifying where they can break down | Every patient’s care scenario. Always think. How can this patient or process deteriorate? What can I do to prevent or identify deterioration early?
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Sensitivity to Operations | Each employee in the organization pays close attention to what is or isn’t working | Daily Check In, Unit Based Bundles, Watcher programs, Brief/Exec/Staff/Review/Monthly quality audits, Daily Leadership Rounding | Daily standard work for every employee
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Commitment to Resilience | Timely response to failures while continuing to explore new solutions | Just In Time Simulation Programs, Second Victim Program, Active ongoing PDSA and LEAN cycles, Unit Based Peer to Peer Coaching | Precursor or serious safety event occurrence
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Deference to Expertise | Utilize content experts in the action planning and correction to prevent recurrence of problems or issues | Include family members in improvement work Utilize front line staff in improvement work Utilization of Shared Leadership Committees for input/feedback Condition Councils Use of PRAC for input on operations | All improvement efforts

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Level 2 Reliability: Human Factors and Reliability Science
When these tactics are used expect <5 failures out of 100 opportunities or 99% reliability

Tactic | Description | Example | Accessibility
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Creating Intentional Redundancy | Building a safety net into the required work steps | Two patient identifiers independent double check for high alert medications | A mission critical step which MUST be accomplished with the first execution
Decision aids and reminders built into the system | Use of technology and or algorithms to make decisions | Visual cues to remind of fusable elements Warning alerts in Cerner | Low volume or high risk task which requires detailed, just in time knowledge of next step
Differential | Utilizing visual cues to set off alerts or processes or medications | Color coding of pharmacy orders Reminders of look alike sound alike medications Alerts for same similar patient names on a unit | Situations which rely on visual identification of a supply, tool or situation specific knowledge
Real time Identification of Failure | Staff report incidents in the environment as they identify them | Event reporting systems Calling for security with escalation Calling for environmental services for spills Send equipment to be used when necessary | Standard Work for all employees
Default as desired action | Orders and order sets embedded in care based on patient needs | Staff in giving the flu shot on certain patients Nurse driven algorithms Care sets based on inclusion criteria | Information technology processes
Standardization of essential tasks | Defined care elements by discipline | Standardization of work steps for specific processes and procedures Standard work Interruption reduction of high risk tasks | High volume processes
Scheduling key tasks | Time stamping work steps | Pharmacy daily work schedule to include refills at a set time every day Indicate care times | High volume, highly structured or high risk processes Process with steps which must be sequenced sequentially

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