

Consensus Results

All levels of maturity in the High Reliability Maturity Model, by component, are described in this report. The highlighted areas reflect the maturity level based on your organization's consensus responses to the Assessment questions.

Beginning	Developing	Advancing	Approaching
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Leadership	Beginning	Developing	Advancing	Approaching
<b>Board</b>	Board quality focus is nearly exclusively on regulatory compliance	Full Board's involvement in quality limited to hearing reports from its quality committee	Full board engaged in development of quality goals and approval of quality plan; regularly reviews adverse events and progress on quality goals	Board commits to goal of high reliability for all clinical services
<b>CEO/ Management</b>	CEO/management quality focus is nearly exclusively on regulatory compliance	CEO acknowledges need for plan to improve quality; delegates development and implementation of plan to subordinate	CEO leads development and implementation of proactive quality agenda	Management aims for zero failure rates for all vital clinical processes; some demonstrate zero or near-zero failure rates
<b>Physicians</b>	Physicians rarely lead quality improvement activities; overall physician participation in these activities is low	Physicians champion some quality improvement activities; physician participation in these activities occurs in some areas but is not widespread	Physicians often lead quality improvement activities; physician participation in these activities occurs in most areas, but we still have some important gaps	Physicians routinely lead clinical quality improvement activities and accept leadership of other appropriate clinicians; physician participation in these activities is uniform throughout the organization

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<b>Quality strategy</b>	Quality is not identified as central strategic imperative	Quality is one of many competing strategic priorities	Quality is one of our organization's top 3 or 4 strategic priorities	Quality is the highest priority strategic goal of the organization
<b>Quality measures</b>	Quality measures not prominently displayed or reported internally or publicly; only measures used are those required by outside entities; not part of reward systems	Few quality measures reported internally; few or none reported publicly; not part of reward systems	Routine internal reporting of quality measures begins; first measures reported publicly; first quality metrics introduced into staff reward systems	Key quality measures are routinely displayed internally and reported publicly; reward systems for staff prominently reflect accomplishment of quality goals
<b>Information technology</b>	Provides little or no support for quality improvement	Supports some improvement activities, but principles of safe adoption not often adhered to	IT solutions support many quality initiatives; organization commits to principles and practice of safe adoption	Safely adopted IT solutions are integral to sustaining improved quality

<b>Safety Culture</b>	<b>Beginning</b>	<b>Developing</b>	<b>Advancing</b>	<b>Approaching</b>
<b>Trust</b>	No assessment of trust or intimidating behavior	First codes of behavior adopted in some clinical departments	CEO and clinical leaders establish a trusting environment among all staff by modeling appropriate behaviors and championing efforts to eradicate intimidating behaviors	High levels of (measured) trust exist in all clinical areas; self-policing of codes of behavior in place

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<b>Accountability</b>	Emphasis on blame; discipline not applied equitably or with transparent standards; no process for distinguishing "blameless" from "blameworthy" acts	Beginning recognition of importance of equitable disciplinary procedures; some clinical departments adopt these procedures	Managers at all levels accord high priority to establishing all elements of safety culture; adoption of uniform equitable and transparent disciplinary procedures begins organization-wide	All staff recognize and act on their personal accountability for maintaining a culture of safety; full adoption of equitable and transparent disciplinary procedures
<b>Identifying unsafe conditions</b>	Root cause analysis limited to adverse events; close calls ("early warnings") not recognized or evaluated	Pilot "close call" reporting programs begin in few areas; some examples of early intervention to prevent harm	Staff in many areas begin to recognize and report unsafe conditions and practices before they harm patients	Close calls and unsafe conditions routinely reported, leading to early problem resolution, before patients are harmed; results routinely communicated
<b>Strengthening systems</b>	Limited or no effort to assess system defenses against quality failures and remedy weaknesses	RCAs begin to identify same weaknesses in system defenses in many clinical areas; systematic efforts to strengthen them are lacking	System weaknesses catalogued and prioritized for improvement	System defenses proactively assessed; weaknesses proactively repaired
<b>Assessment</b>	No measures of safety culture	Some measures of safety culture undertaken but are not widespread; little if any attempt to strengthen safety culture	Measures of safety culture adopted and deployed organization-wide; beginning efforts to improve	Safety culture measures part of strategic metrics reported to Board; systematic improvement initiatives underway to achieve fully functioning safety culture

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Performance Improvement	Beginning	Developing	Advancing	Approaching
<b>Methods</b>	No formal approach to quality management adopted by organization	Exploration of modern process improvement tools beginning	Organizational commitment to adopt full suite of Robust Process Improvement (RPI) tools	Adoption of RPI tools accepted fully throughout organization
<b>Training</b>	Limited to compliance personnel or to quality department	Recognition that training in PI tools outside quality department is critical to success	Training of selected staff in RPI underway; plan in place to broaden training	Training in RPI is mandatory for all staff, as appropriate for their jobs
<b>Spread</b>	No commitment to widespread adoption of improvement methods	Pilot projects using some new tools conducted in a few areas	RPI used in many areas to improve business processes as well as clinical quality and safety; positive ROI achieved	RPI tools used throughout organization for all improvement work; patients engaged in redesigning care processes; RPI proficiency required for career advancement
<b>Percentage (%)</b>	<b>7.14</b>	<b>64.29</b>	<b>14.29</b>	<b>14.29</b>