Joint Commission Center for Transforming Healthcare

**High Reliability Maturity Model**
**Safety Culture Domain Actions**

| Component/Actions | Currently Doing | What Progress Has Been Made? | Plan to Start Doing |
|---|---|---|---|
| **Trust:** | | | |
| Give staff formal feedback on actions taken for event reports | | | |
| Provide organized support for clinicians involved in an incident | | | |
| Consistent implementation of organization-wide code of conduct applicable to all physicians, staff and managers/leadership | | | |
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| **Accountability:** | | | |
| Create policy and process for use of incident decision tree algorithm | | | |
| Educate all staff, employed and non-employed physicians and leadership about incident decision tree algorithm | | | |
| Consistent implementation an incident decision tree algorithm | | | |

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|---|---|---|---|
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| **Identifying Unsafe Conditions:** | | | |
| Implement use of “CUS” patient safety technique (TeamSTEPPS) | | | |
| Purchase and implement electronic reporting | | | |
| Revise existing reporting system | | | |
| Evaluate near misses versus events | | | |
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| **Strengthening Systems:** | | | |
| Implement common cause analysis | | | |
| Establish a Patient/Family Advisory Council | | | |
| Track issues raised at daily operations briefing; formal process to investigate trends | | | |
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|---|---|---|---|
| **Assessment:** | | | |
| Begin routinely (every 2-3 years) assessing safety culture using a validated tool | | | |
| Provide Assessment results to all departments and require creation of action plans to improve culture | | | |
| Establish formal reporting process for progress with action plans/provide routine updates to Board | | | |
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