

## Stages of Organizational Maturity: Safety Culture and High Reliability<sup>1</sup>

*For each item in Column #2, circle the category that best describes your facility's Stage of Organizational Maturity*

#	Safety Culture	Beginning	Developing	Advancing	Approaching
1	Trust	Trust or intimidating behavior is not assessed.	First codes of behavior are adopted in some clinical areas.	CEO and clinical leaders establish a trusting environment for 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 is in place.
2	Accountability	Emphasis is on blame; discipline is not applied equitably or with transparent standards; no process exists for distinguishing "blameless" from "blameworthy" acts.	The importance of equitable disciplinary procedures is recognized, and 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 across the organization.	All staff recognize and act on their personal accountability for maintaining a culture of safety; equitable and transparent disciplinary procedures are fully adopted across the organization.
3	Identifying unsafe conditions	Root cause analysis is limited to adverse events; close calls ("early warnings") are not recognized or evaluated.	Pilot "close call" reporting programs begin in few areas; some examples of early intervention to prevent harm can be found.	Staff in many areas begin to recognize and report unsafe conditions and practices before they harm patients.	Close calls and unsafe conditions are routinely reported, leading to early problem resolution before patients are harmed; results are routinely communicated.
4	Strengthening systems	Limited or no effort exist to assess systems defenses against quality failures and to remedy weaknesses.	RCAs begin to identify the same weaknesses in system defenses in many clinical areas, but systematic efforts to strengthen them are lacking.	System weaknesses are cataloged and prioritized for improvement.	System defenses are proactively assessed, and weaknesses are proactively repaired.
5	Assessment	No measures of safety culture exist.	Some measures of safety culture are undertaken but are not widespread; little if any attempt is made to strengthen safety culture.	Measures of safety culture are adopted and deployed across the organization; efforts to improve safety culture are beginning.	Safety culture measures are part of strategic metrics reported to the board; systematic improvement initiatives are under way to achieve a fully functioning safety culture.

1. Chassin MR, Loeb JM. 2013. High-Reliability HealthCare: Getting There from Here. *The Milbank Quarterly*. 91:3; 459-490

## Stages of Organizational Maturity: Leadership and High Reliability<sup>1</sup>

*Circle the category that best describes your facility's Stage of Organizational Maturity*

#	Leadership	Beginning	Developing	Advancing	Approaching
1	Board	Board's quality focus is nearly exclusively on regulatory compliance.	Full board's involvement is limited to hearing reports from its quality committee.	Full board is engaged in the development of quality goals and approval of a quality plan and regularly reviews adverse events and progress on quality goals.	Board commits to a goal of high reliability (i.e., zero patient harm) for all clinical services.
2	CEO / Management	CEO/managements quality focus is nearly exclusively on regulatory compliance.	CEO acknowledges need for plan to improve quality and delegates the development and implementation of a plan to a subordinate.	CEO leads the development and implementation of a proactive quality agenda.	Management aims for zero patient harm for all vital clinical processes; some demonstrate zero or near-zero rates of harm.
3	Physicians	Physicians rarely lead quality improvement activities; overall participation by physicians in these activities is low.	Physicians champion some quality improvement activities; physicians participate in these activities in some areas but not widely.	Physicians often lead quality improvement activities; physicians participate in these activities in most areas, but some important gaps remain.	Physicians routinely lead clinical quality improvement activities and accept the leadership of other appropriate clinicians; physicians' participation in these activities is uniform throughout the organization.
4	Quality strategy	Quality is not identified as a central strategic imperative.	Quality is one of the competing strategic priorities.	Quality is one of the organization's top three or four strategic priorities.	Quality is the organization's highest –priority strategic goal.
5	Quality measures	Quality measures are not prominently displayed or reported internally or publicly; the only measures used are those required by outside entities and are not part of reward systems.	Few quality measures are reported internally; few or none are reported publicly and are not part of reward systems.	Routine internal reporting of quality measures begins, with the first measures reported publicly and the first quality metrics introduced into staff reward systems.	Key quality measures are routinely displayed internally and publicly reported; reward systems for staff prominently reflect the accomplishment of quality goals.
6	Information technology	IT provides little or no support for quality improvement.	IT supports some improvement activities, but principles of safe adoption are not always followed.	IT supports many quality initiatives; the organization commits to principles and the practice of safe adoption.	Safely adopted IT solutions are integral to sustaining improved quality.

1. Chassin MR, Loeb JM. 2013. High-Reliability HealthCare: Getting There from Here. *The Milbank Quarterly*. 91:3; 459-490