High Reliability is the study of human performance in complex systems and includes: systems thinking, event analysis, techniques to minimize human error, techniques to improve processes, and tactics to move organizations to a culture where patient safety is at the core of all activities.

Many healthcare systems are adopting concepts used by High Reliability Organizations (HROs) like aviation and nuclear power to meet production requirements while experiencing fewer than their fair share of accidents. The HANYS-HPI High Reliability Institute will provide leaders with strategies, tactics and tools needed to move their organizations to becoming HROs.

Participants will be able to take learnings back to their organizations and implement specific HRO actions designed to reduce human error, improve system reliability and reinforce accountability to meet practice expectations. The four 2-day seminars will take place approximately every two months at regional locations covering the following topics:

**Seminar 1:**
**Day 1: High Reliability Healthcare** – Overview of High Reliability strategic principles and theory needed to build a solid foundation and understanding of how and why the tactical applications of HRO theory improve people and process reliability.
**Day 2: Human Performance and Error Prevention** – This session will cover the science of safety and human performance, focusing on human error and evidenced-based error prevention techniques that are proven to reduce human error and resulting harm events by 80%.

**Seminar 2:**
**Day 1: Patient Harm** – Information on patient harm, harm measurement and methods leaders can use to make harm visible within their organizations to reduce complacency and raise awareness of the risk factors confronting healthcare professionals each and every day.
**Day 2: Safety Culture** – Culture is a system-level behavior-shaping force, affecting day-to-day decisions that impact safety, quality and the experience of care. This session defines leadership’s role in building and reinforcing a culture of safety each and every day.

**Seminar 3:**
**Day 1: Accountability Systems** – Positive accountability systems build intrinsic desire on the part of staff, leaders and physicians to meet expectations. This session will offer various tactical leadership techniques that should be part of every healthcare leader’s standard daily work.
**Day 2: Accountability Implementation-Fair & Just Culpability Management** – Fundamental to every HRO is the need to encourage robust error and event reporting along with clear lines between acceptable and unacceptable behavior. This session will provide tools to distinguish unintentional errors from reckless behaviors and how to appropriately respond to each.

**Seminar 4:**
**Day 1: Leading Learning** – This session will provide an understanding of how HROs build resiliency by learning from adverse events and leadership’s role in owning this process. Enhancements to the Root Cause Analysis process will be covered as well as learning from lesser events through Apparent Cause Analysis and Local Learning systems.
**Day 2: Safety and Reliability Culture Sustainment** – Reviews required organizational structures necessary to promote long-term sustainment of reliability improvement efforts including safety dashboards, metrics and control loops, safety coaches, hiring criteria, and annual performance reviews to reinforce an organizational commitment to safety and reliability.

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