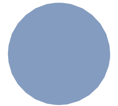
Institute for Healthcare Improvement

SAFE & RELIABLE Healthcare

IHI TOOL



# Diagnostic Tool:

## A Framework for Safe, Reliable, and Effective Care

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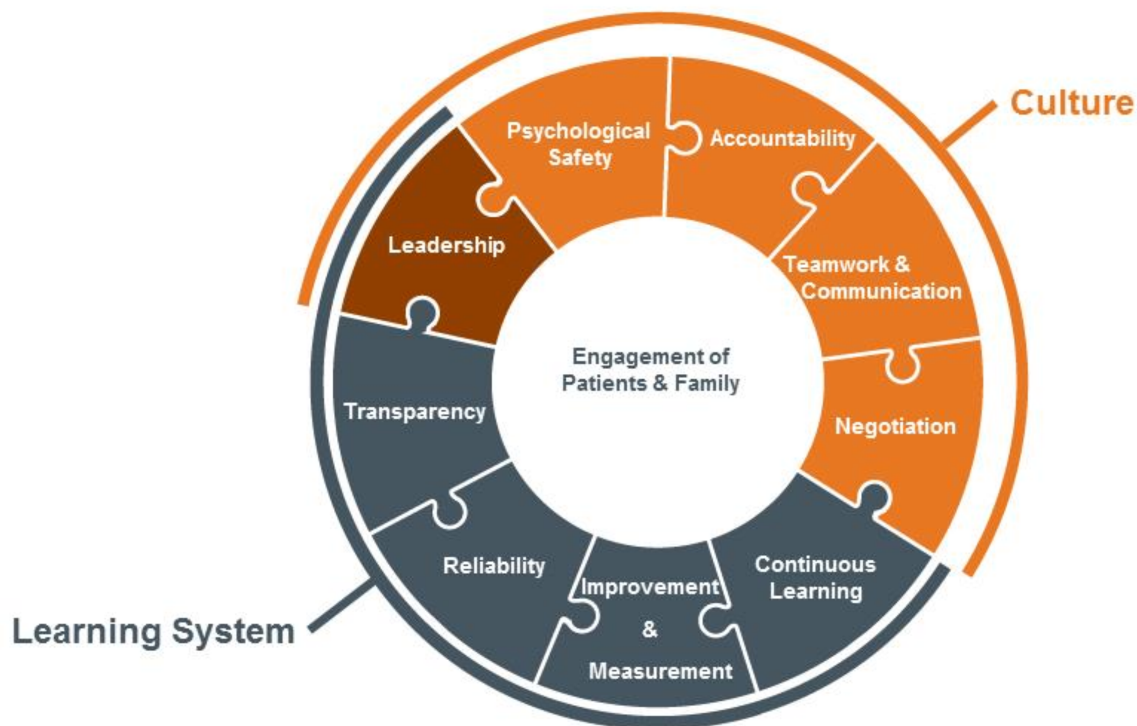
# Introduction

This diagnostic tool is intended to be used by organizations to assess their performance on the framework components presented in the white paper, *Framework for Safe, Reliable, and Effective Care*. Made up of two foundational domains — culture and the learning system — along with nine interrelated components, with patients and families at the core, the framework brings together succinctly and in one place all the strategic, clinical, and operational concepts that are critical to achieving safe, reliable, and effective care. Organizations can use the framework as a roadmap or as a diagnostic tool to determine how well (or even if) they are pursuing the different components of the framework.

**Framework for Safe, Reliable, and Effective Care**



## 1. Psychological Safety

Creating an environment where people feel comfortable and have opportunities to ask questions, ask for feedback, be respectfully critical, and suggest ideas.

| Just beginning | Making progress | Significant impact | Exemplary |
|---|---|---|---|
| • Policies may state that staff should feel psychologically safe but leaders and managers do little to actively practice or encourage this.<br>• Staff are reluctant to speak up for fear of ridicule or negative reactions from fellow staff, even when there is imminent danger to the patient.<br>• Feedback is only provided through formal process such as appraisal and this feels like a superficial exercise to most staff.<br>• Staff rarely receive feedback after reporting an adverse event. | • Some leaders and middle managers model the behaviors associated with psychological safety but this is not standardized across the organization.<br>• Many staff don't feel comfortable speaking up although they may be likely to in cases of imminent danger to a patient.<br>• Staff are not generally forthcoming with innovations or suggestions as they feel they won't be taken seriously.<br>• Staff usually receive superficial feedback after reporting an adverse event. | • All leaders and middle managers encourage staff to speak up, address behaviors that do not support psychological safety, and are transparent with communications and data.<br>• The hierarchy is not flat but there are many examples of learning from feedback or appropriate criticism.<br>• Innovations that staff suggest are regularly tested and implemented after successful tests.<br>• All staff receive detailed feedback and thanks for reporting an adverse event. | • All staff feel comfortable to ask questions, ask for feedback, be appropriately critical, and suggest innovations.<br>• All staff are actively encouraged to do the above; it is expected at all levels of the organization.<br>• There is a flat hierarchy that supports this behavior and a learning system that is responsive to the information.<br>• Leaders clearly demonstrate these activities and behaviors.<br>• Learning from adverse events is routinely and effectively shared across the organization. |

**Please provide a brief description of the type of data or other evidence you used to inform your choice:**

## 2. Accountability

Being held to act in a safe and respectful manner and given the training and support to do so. This framework component underscores the importance of holding people to account for their actions, but not for flaws in processes or systems. Each individual is accountable to others for acting in ways that embody organizational values, and each individual is accountable as a team member to be committed, self-managing, competent, and courageous.

| Just beginning | Making progress | Significant impact | Exemplary |
|---|---|---|---|
| • The organization continues to seek out and punish those involved in errors and harm.<br>• There is no differentiation between a systems contribution and individual contribution to errors and harm.<br>• Culture is not measured. | • There is some understanding of system contributions to harm but there remains a strong focus on individual contributions.<br>• The organization has adopted a just culture approach but has not yet implemented throughout.<br>• Middle managers have not been trained in use of a just culture algorithm or other methods to investigate events.<br>• Culture is measured every few years but little action occurs as a result. | • Leaders have deep understanding of system contributions to errors and harm and this is the focus of learning but not shared by all staff.<br>• Some staff are being held accountable to others for their behaviors that support organizational values and responsibility for their actions.<br>• The model is not equally applied.<br>• Middle managers have been trained in use of a just culture algorithm or other methods to investigate events.<br>• Culture is measured every year and plans drawn up in areas of concern, although follow up is varied. | • All staff are able to differentiate between individual and systems issues when holding individuals to account. Systems contributions are the focus of learning and improvement in line with a just culture algorithm.<br>• The environment is perceived as just and fair by all staff.<br>• All staff understand their roles and responsibilities and are accountable to their execution.<br>• Culture is measured every year and plans drawn up in areas of concern that result in action and improvement that is reflected in improved culture scores. |

**Please provide a brief description of the type of data or other evidence you used to inform your choice:**

## 3. Teamwork & Communication

Strong teams work together to plan forward, reflect back, communicate clearly, and manage risk. This includes developing a shared understanding, anticipating needs and problems, agreeing on methods to manage these as well as appropriate resolution to conflict situations.

| Just beginning | Making progress | Significant impact | Exemplary |
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| • Communication is unstructured and communication failures are commonplace.<br>• Handovers and briefings do not follow a set pattern or use a structured approach.<br>• Behavioral norms and expectations may differ depending on seniority, profession, or personality.<br>• People don't routinely identify themselves as part of a multidisciplinary team.<br>• Team members do not feel comfortable raising concerns.<br>• There is no investment in teamwork training or capability development. | • Some standard communication is structured but there is variation in how this is executed (e.g., not all team members engage with briefings).<br>• Some communication failures occur.<br>• Behavioral expectations apply to all staff but there are many examples of this not being adhered to.<br>• A small proportion of team members may be comfortable challenging or raising concerns.<br>• Some teams are known for being good places to work.<br>• There is limited investment in teamwork training or capability development. | • Most standard communication is structured and practice matches the standard process the majority of the time.<br>• Multidisciplinary teamwork is the norm.<br>• Most team members are comfortable raising concerns.<br>• Behavioral norms apply to the majority of the workforce although a few exceptions still exist.<br>• Communication failures are rare and normal communication is very standardized.<br>• Most teams function well.<br>• Most staff are involved in some teamwork training. | • All standard communication is structured and exceptions are extremely rare.<br>• The team dynamic supports psychological safety and all members of the team, regardless of seniority or familiarity, feel that their opinion is valued and that they can raise concerns.<br>• Teams agree on norms of conduct and behavior and act accordingly. Behavior that does not support this is quickly eradicated.<br>• Communication failures are rare.<br>• All staff receive teamwork training. |

**Please provide a brief description of the type of data or other evidence you used to inform your choice:**

| 4. Negotiation | | | |
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| Gaining genuine agreement on matters of importance to team members, patients, and families. Identifying and focusing on specific initiatives to improve quality often may require a negotiation between and among different stakeholders. The skill can also be applied to working with patients when collaborating on a treatment plan. Ensuring that staff have the skills and opportunity to apply the five propositions for negotiations to achieve non-adversarial bargaining is essential to achieving operational excellence. | | | |
| • Few if any staff are able to use effective negotiation tactics to engage others in change.<br>• Differences are expressed in methods that result in poor teamwork and lack of agreement. | • Some staff are skilled in and able to successfully negotiate with peers.<br>• Conflicts continue to lead to poor behavior and are seldom resolved in the interest of the patient. | • Many of the differences in the approach to improvement work and process changes needed are negotiated with the team.<br>• Resolution to conflicts is achieved in a way that all parties benefit and patient care is improved. | • All staff are able to negotiate through differences. Collaborative staff differentiate position from interests. Staff use appreciative inquiry.<br>• Staff report a high level of respect and minimal disruptive behaviors due to the ability to reach agreement. |
| **Just beginning** | **Making progress** | **Significant impact** | **Exemplary** |
| **Please provide a brief description of the type of data or other evidence you used to inform your choice:** | | | |

## 5. Continuous Learning

Continuous learning entails the proactive and real-time identification of potential and actual defects and harm. Where defects occur, learning also occurs and the defect is prevented from occurring again in the same or a different area of the organization.

| Just beginning | Making progress | Significant impact | Exemplary |
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| • Defects are collected in reporting systems.<br>• Learning from safety projects, root cause analyses, and reporting systems is shared very little across the organization.<br>• A few care locations use huddles when they are not too busy.<br>• Organizational data shows that learning rarely or never occurs, and harm, errors, and defects continue to occur at stable or increasing rates. | • Organization leadership has established a system for sharing the learning from improvement activities, root cause analyses, and reporting systems but this may not be used in every opportunity.<br>• Some learning boards exist as a vehicle for understanding the current state and planning.<br>• Huddles are held in care locations routinely.<br>• Organizational data shows that, for the most part, certain errors, harm, or defects recur on a regular basis. There may be some examples of learning in pilot populations. | • Organization leadership has established a system for sharing the learning from most improvement activities, root cause analyses, and reporting systems across the organization.<br>• In addition, learning boards exist in most care locations and are used during daily huddles by area leadership to reflect back and plan ahead.<br>• Organization leadership make rounds using the learning boards as a vehicle for discussion and spread of learning.<br>• Organizational data shows that some learning occurs by removing errors and defects in some areas but spread of learning remains a challenge. | • Organization leadership has established a system for collecting and understanding successes and defects both within organizations and between them, across the continuum of care.<br>• Learning boards exist in all care locations and are used on a daily basis.<br>• Organizational data clearly indicates that learning has occurred by reducing or removing the occurrence of certain errors, harm, or safety issues across the organization. |

**Please provide a brief description of the type of data or other evidence you used to inform your choice:**

| 6a. Improvement | | | |
|---|---|---|---|
| The capability of an organization to: 1) obtain and execute on the skills and competencies required to undertake improvement throughout the organization, and 2) establish, manage, and analyze data for improvement in a timely and routine manner to meet the objectives and expected results of the organization's improvement plan. (*From Framework: Improving work processes and patient outcomes using standard improvement tools including measurements over time).* | | | |
| • Few if any improvement projects designed to improve safe and reliable care are underway that are guided by an organization-wide improvement framework and model.<br>• The organization provides training in improvement methods to staff in a limited fashion. | • A number of improvement projects designed to improve safe and reliable care have achieved measureable improvements, guided by an organization-wide improvement framework and model.<br>• Some improvement projects involve multidisciplinary teams. | • A number of quality improvement projects designed to improve safe and reliable care have achieved sustained improvement, guided by an organization-wide improvement framework and model.<br>• The organization spreads learning from improvement projects systematically across the organization. | • The organization has embedded quality improvement in all areas of the organization.<br>• Teams have achieved and sustained measureable improvements across the continuum of care.<br>• The organization consistently shares and spreads improvements across the organization, the continuum, and with key stakeholders. |
| **Just beginning** | **Making progress** | **Significant impact** | **Exemplary** |
| **Please provide a brief description of the type of data or other evidence you used to inform your choice:** | | | |

## 6b. Measurement

The capability of an organization to: 1) obtain and execute on the skills and competencies required to undertake improvement throughout the organization, and 2) establish, manage, and analyze data for improvement in a timely and routine manner to meet the objectives and expected results of organization's improvement plan. (*From Framework: Improving work processes and patient outcomes using standard improvement tools including measurements over time.)*

| Just beginning | Making progress | Significant impact | Exemplary |
|---|---|---|---|
| • The organization uses data to measure performance, but only a few areas use data to support and inform activities designed to improve safe and reliable care.<br>• There is limited ability to communicate information across systems. | • The organization uses data to measure performance and to support many improvement projects designed to improve safe and reliable care.<br>• The organization has established a number of data systems to allow for some cross-organizational measures. | • The organization uses data to measure performance and to support almost all projects designed to improve safe and reliable care.<br>• The organization has established a number of data systems which it uses routinely to share system-of-care performance information across key partners and stakeholders in the organization. | • The organization uses data to drive all improvement measures at both the whole system (across the continuum) and subsystem level.<br>• Data systems allow for highly effective communication within and across all continuum partners and with key stakeholders in a manner that informs the knowledge and actions required to meet the shared objectives. |

**Please provide a brief description of the type of data or other evidence you used to inform your choice:**

## 7. Reliability

Applying best evidence and minimizing non-patient-specific variation with the goal of failure-free operation over time. Reliability of processes is not achieved by accident. It requires an approach that begins with reliability in mind, designs processes that include human factors considerations, and has a measurement system to ensure that the processes continue to be reliable and capable of achieving the desired results.

| Just beginning | Making progress | Significant impact | Exemplary |
|---|---|---|---|
| • There are few standardized processes and most processes are evolved rather than designed.<br>• Policies and procedures may exist but do not reflect common practice; staff may have developed workarounds or individuals methods in preference.<br>• Individuals use processes that are person specific, reflecting individual autonomy, and not patient centered or standardized.<br>• Reliability is based on hard work and vigilance.<br>• Outcomes are variable. | • Processes are standardized but without a focus on human factors and without deliberate efforts to ensure high levels of reliability.<br>• Some staff follow due process but there are still examples of staff deviating from process in favor of personal preference.<br>• While processes may be intentionally developed, their reliability is rarely tested or measured. Implementation usually involves publishing the process and requesting that staff now follow it.<br>• Processes are not routinely linked to outcomes. | • Staff are trained in a methodology that includes human factors to ensure that processes are reliable and achieving desired outcomes, although implementation is varied.<br>• Staff still occasionally deviate from agreed process but usually in the best interest of the patient, although not always.<br>• The reliability of key processes may be monitored over time but some processes are not measured. | • All processes are designed, tested, and monitored in terms of reliability and outcomes. There is an agreed methodology to achieve this that staff involved in process management adhere to.<br>• Processes are regularly reviewed and updated in response to learning, suggestions, or schedule.<br>• Processes are standardized but include flexibility to allow patient preference to be taken into account.<br>• It is rare for any staff to deviate from process other than in service of patient needs or preference. |

**Please provide a brief description of the type of data or other evidence you used to inform your choice:**

## 8. Transparency

Operational transparency exists when leaders, staff, patients and their families, organizations, and the community are able to visibly see the activities involved in the learning process. It provides clarity over decision making and monitoring of performance. Transparent organizations openly share data and other information concerning safe, respectful, and reliable care with staff and their partners and families and encourage a dialogue regarding shared information.

| Just beginning | Making progress | Significant impact | Exemplary |
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| • The organization meets its legal or minimum requirements in terms of publishing data or communicating with a patient or family following an adverse event.<br>• Data or information shared is high level and not used for learning or improvement.<br>• Leaders rarely spend time visiting the “shop floor.”<br>• Data is not typically displayed around the organization; where it is, data tends to be high level or may be out of date.<br>• Patients and families are not involved in adverse event investigations. | • A small proportion of leaders visit the “shop floor” at least twice a year.<br>• Learning boards may be in use in a couple of areas but they are not regularly updated so the information may not be current.<br>• Learning boards are updated in preparation for a visit from a leader or visitor but are not used routinely by staff.<br>• Patients and families have some involvement in some adverse event investigations or improvement activities but this is relatively superficial. | • Leaders spend time on the “shop floor” at least every month and review local data with teams.<br>• Some managers are use learning boards and encourage staff to participate in the process of populating the learning boards.<br>• Patients and families are deeply involved in all investigations of adverse events.<br>• Patient and families are routinely involved in improvement activities, although this involvement may be quite limited at times. | • Leaders create the expectation that all areas are using learning boards to share the process of learning and improvement.<br>• Senior leaders spend a significant proportion of time reviewing learning boards and highlighting learning.<br>• Managers are adept at using learning boards to share the improvement journey.<br>• Patients and families are actively engaged in the improvement functions of the organization and feel that they can trust the communication they receive. |

**Please provide a brief description of the type of data or other evidence you used to inform your choice:**

## 9. Leadership for Improvement

The capability of the leadership of the organization to set clear and measurable goals, expectations, priorities, and accountability for the improvement of safe and reliable care. The support necessary to integrate improvements and learning across the continuum is provided. *(From Framework: Facilitating and mentoring teamwork, improvement, respect, and psychological safety.)*

| Just beginning | Making progress | Significant impact | Exemplary |
|---|---|---|---|
| • There are no clear organization-level goals related to safe and reliable care.<br>• Expectations and priorities for departments, services, or practices is seen as a department or service responsibility rather than requiring overall organizational leadership.<br>• Leadership for safe and reliable care is not coordinated across departments or services.<br>• Very little, if any, learning from safety projects and other reporting vehicles is shared across the organization. | • Senior leadership has prioritized some organization-level goals for safe and reliable care, which they actively monitor and support.<br>• Improving the culture of safety and improvement is specifically named as an organizational goal.<br>• Leadership focuses on the system of care and supports some local leaders to facilitate coordination of activities to improve safe and reliable care across the services involved. | • Leadership is actively engaged in monitoring and supporting most organization-level goals for safe and reliable care, including improving the culture of safety and improvement.<br>• Senior leadership focuses on the system of care and supports most local leaders in integrating and supporting activities to improve safe and reliable care and culture across the organization. | • Senior leadership is actively engaged in monitoring and supporting all goals to improve safe and reliable care and culture.<br>• Senior leadership focuses on the system of care and supports all local leaders in integrating and supporting activities designed to improve safe and reliable care and culture across the continuum. |

**Please provide a brief description of the type of data or other evidence you used to inform your choice:**

## 10. Person-Centered Care

All the activities of the organization can clearly and easily be associated with providing best possible care and outcomes for patients and their families. Successful organizations perceive patients as integral members of both care and improvement teams and have a supporting infrastructure that empowers the individual to act in this role. Patients and their families are welcomed into discussions about their care. Care is delivered in agreement with the views of the patient and their family.

At this point we invite you to reflect on each component of the Framework for Safe, Reliable, and Effective Care and consider to what extent you currently partner with patients and their families with a view to identifying opportunities to partner in new and effective ways. We have included an example to aid your thinking.

| | |
|---|---|
| Psychological Safety: | (e.g., During patient consultations, our first question is “What matters to you?” rather than “What’s the matter?” We use this to give the patient clear permission to help drive the care they receive.) |
| Teamwork & Communication: | |
| Accountability: | |
| Negotiation: | |
| Continuous Learning: | |
| Improvement & Measurement: | |
| Reliability: | |
| Transparency: | |
| Leadership for Improvement: | |

**Please provide a brief description of the type of data or other evidence you used to inform your choice:**