Safe Systems Improvement Tool:
Congregate Care

2022
REFERENCE
GUIDE

ACKNOWLEDGEMENTS

A large number of individuals have collaborated in the development of the congregate care version of the Safe Systems Improvement Tool. This information integration tool is designed to support systems-focused event analysis. The SSIT is an open domain tool. The copyright is held by the Praed Foundation to ensure that it remains free to use. Training and certification is expected for appropriate use.

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1. INTRODUCTION

SAFE SYSTEMS IMPROVEMENT TOOL

The pursuit of learning is the characteristic that distinguishes high-quality service delivery systems. Organizations with a well-developed culture of excellence find ways to successfully identify improvement opportunities, implement strategies for change, evaluate change over time, and hardwire what they learn.

Teams are a crucial network of professionals in providing high-quality care. Safe, effective, reliable teams engage in the following six habits:

1) Spend time identifying what could go wrong.
2) Talk about mistakes and ways to learn from them.
3) Test change in everyday work activities.
4) Develop an understanding of "who knows what" and communicate clearly.
5) Appreciate colleagues and their unique skills.
6) Make candor and respect a precondition to teamwork.

In short, safe, reliable, effective teams plan forward, reflect back, test change, communicate clearly, appreciate their colleagues, and manage professionalism.

The following is a simple information integration tool designed to be the guide and output of a conversation within and across agency teams (e.g., milieu, clinical and administrative) — essentially, a transparent and supportive event analysis. It is a tool for reflecting back on events, such as serious incidents, in the interests of systems learning and improvement — sharing collective accountability to grow and change as we strive for optimal youth experiences and outcomes. There are six key principles of a communimetric measure that apply to understanding this instrument.

SIX KEY PRINCIPLES

1. Items are included because they are relevant and inform system change opportunities.
2. Ratings translate into action levels designed to support systems improvement activities.
3. Ratings are made to identify an opportunity for improvement independent of a current intervention (i.e., workaround).
4. Ratings are designed to promote objectivity and avoid bias.
5. Ratings use a recency window to keep the assessment relevant to current experiences surrounding the serious incident.
6. It is about the "what and how," not the "who and why." Items are organized into domains to engage rich discussion on the complexity of factors affecting client care.

This is an effective assessment tool for use in event analysis, such as the debriefing of serious or critical events. It guides an agency through a reflective assessment process where professionals discuss the systemic contributors to an unwanted event. Rather than holding a youth or single staff responsible for a serious incident like a restraint or runaway, the SSIT assumes the best intentions of all involved and instead dives supportively into how system factors misaligned and contributed to harm.

Those engaged in the helping professions are tasked with safety-critical, dynamic, interdependent work filled with competing contingencies and ambiguities. The path to a client's safety and well-being is rarely clear or easy and nearly always complex and uncertain. The well-being and safety of youth are inextricably connected to the health of the "system" serving them. The SSIT was designed to help systems assess their own health and how strengths and weaknesses contribute to youth(s) experiences. This assessment, while invaluable, requires vulnerability and candor. Such phenomenon arises from an organizationally supported culture of **psychological**

safety—professionals being accepted, respected, supported, empowered to speak up, and free to take an interpersonal risk without fear of judgment.

The SSIT for congregate care is designed help agencies learn and improve from serious incidents with the aim of reducing future incidents. With this in mind, the SSIT's ratings translate to action levels for the agency and are generally intended for use in aggregate. So rather than take one-off actions from a one review in isolation, the SSIT exists to thread learnings together across reviews, to advocate for strategic and effective system improvements.

REFERENCE GUIDE STRUCTURE

This reference guide is divided into the following four parts:

Section One: origins, overarching purpose, and the general structure of how items are rated

Section Two: domains and items, item definitions, descriptive rating anchors, and guidance (i.e., "Questions to Consider") in assessing the items.

Section Three: scoresheet as a template for case reviews

Section Four: sharing the "system's story" of a critical incident and advocating for strategic quality improvement work to support safe, effective, and reliable care of children and families.

HISTORY AND BACKGROUND

The SSIT was first developed for retrospective use in Tennessee's Department of Children's Services' (TN DCS) critical incident reviews (i.e., Child Death and Near-Death reviews). During critical incident reviews, professionals assigned to work with the family, both past and present, are requested to participate in debriefing. These debriefings are voluntary, supportive, facilitated opportunities for professionals to process their casework, identify barriers and improvement opportunities, and highlight learning. SSIT provides both a guide in facilitating these debriefings (e.g., questions to consider) and an efficient means to capture the complex information provided as a result of debriefings. After debriefings, critical incident reviews are presented to a multi-disciplinary team who dissects the case and relevant findings from a systemic perspective. SSIT is used to facilitate these conversations and to capture rich discussion. SSIT is only completed once, at the closing of every case review. SSIT's scores are aggregated and analyzed on at least a quarterly basis to review findings and discuss trends. In a similar way to how a barometer measures pressures in the atmosphere, SSIT measures pressure existing within organizations and provides a frame for targeted quality improvement work.

Since 2015, the SSIT has been successfully used to support the analysis of deaths and near deaths, reports made to TN DCS' Confidential Safety Reporting System, and critical incident reviews that do not involve death or near death (e.g., staff injuries, incidents where custodial children absconded and were subsequently exploited).

In 2019, Casey Family Programs led a pioneering team of twelve child-welfare jurisdictions to form the National Partnership for Child Safety (NPCS). Their aim is to reduce maltreatment-related fatalities, enhance system safety through the lens of safety science, and advance the child welfare system into the 21st century—a place where technology, community-based family supports, and partnership with public health would effectively reduce the presence of social determinants to poor outcomes and promote holistic health. The SSIT-NPCS was designed with the input of all NPCS jurisdictions as a way to communicate the learnings from their respective critical incident reviews and provide a foundation for informed data-sharing. At of the writing of this Reference Guide, the NPCS has grown to 27 jurisdictions.

In 2020, both domestic and international human service agencies requested a reflective version of the SSIT for use in active client case reviews. Consistent with the lens of safety science and the pursuit of learning organizations, the intent of the SSIT-R is to highlight strengths and inform positive change opportunities for a team delivering client care as well as the larger system providing the context and platform for care.

SSIT BASIC STRUCTURE

The SSIT is organized into three domains to facilitate learning and improvement. While each item is unique and not replicated in other items, the domains are nested. In other words, a youth cared for by professional(s), who works as a team, who operate within an environment. While the domains provide structure to learning, they are not intended to suggest exclusivity. The intention of the domains is to guide the reviewer into a conversation about all system levels.

Professional Domain	Team Domain	Environment Domain
Bias Management	Preparing and Reflecting	Agency Demand-Resource Match
Stress Management	Effective Communication	Agency Technology
Fatigue Management	Professionalism	Agency Policy and Practice
Knowledge Base	Supervisory Support	Agency Training
Documentation	Workload	Agency Physical Environment
Information Integration	Practice Drift	Community Resources

RATING ITEMS

The SSIT assesses the underlying factors that contribute to client care. The SSIT was designed to help systems assess their own health and how strengths and weaknesses may be contributing to a youth's experiences.

Like all Transformational Collaborative Outcomes Management (TCOM) tools, the ratings translate into action levels, intended first to advise the team directly responsible for the client's care but also to the larger system and its quality improvement professionals—who are tasked with understanding and engineering a resilient system that best promotes high-quality care.

Table 1: Basic Ratings Design

Rating	Observation	Appropriate Action Level
0	Area of strength for the team and/or system	Spread strengths to build sustainability. Monitor as new members come on and new demands emerge
1	No impact	No need for action, watchful waiting
2	Influence contributed to event under review	Action likely needed to support goals

A scoring of '2' denotes an item as actionable; it means the item contributed to the event under review and likely benefits from action. Actionable items should be accompanied by a narrative description to support the rating. This combination of quantitative and qualitative data facilitates simple and structured communication on review but also creates a rich database of information over time—allowing for dissection of themes. Providing narrative explanation whenever a strength (i.e., 0) is scored is an optional yet important way to explicitly identify and track strengths over time. Harnessing and cultivating strengths is perhaps one of the best and (unfortunately) lesser used strategies for building a resilient and effective system of care.

2. SSIT DOMAINS AND ITEMS

PROFESSIONAL DOMAIN

This section focuses on factors primarily present within professionals. Largely intrapersonal in focus, this domain centers on the experience, knowledge, perceptions, and skills of professionals carrying for the youth. This domain focuses on behaviors as well as the presence of psychological factors within professionals, like fatigue and stress. Neither this domain nor any domain is created to assign blame; rather this domain offers an organized way to deconstruct perspectives before, during, and after decision-making.

For the **PROFESSIONAL DOMAIN,** the item ratings translate into the following categories and action levels:

0	Spread strengths to build sustainability. Monitor as new members come on and new demands emerge.
1	No impact. No action needed.
2	Action likely needed to support goals.

BIAS MANAGEMENT

Ability to manage a faulty understanding of a situation due to inherent bias(es) (e.g., confirmation bias, cognitive fixation, focusing effect, transference).

Questions to Consider	Ratings & Descriptions	
• Do you experience yourself jumping to conclusions about this youth's intentions or abilities? Does this youth remind you of anyone? Do you carry personal values or beliefs about the youth's identity or experience? How open-minded do you feel when hearing divergent opinions regarding the youth?	0	Clear awareness of potential bias and demonstrates management strategies. Practices candor in disclosing potential bias to teammates.
	1	No impact in caring for the youth at the time of the event.
	2	Bias(es) impacted actions/decisions which contributed to the event under review.

STRESS MANAGEMENT

Ability to manage or prevent psychological strain or tension resulting from adverse or demanding circumstances. Professionals express or exhibit difficulty managing the strains of casework and/or other life circumstances (e.g., divorce, financial strain).

Questions to Consider	Ratings & Descriptions	
• What pressures are you facing, professionally and personally? Is it affecting your work? How do you know when you are stressed? What methods are employed to manage stress?	0	Clear awareness of the effect of stress and demonstrates management strategies. Practices candor in disclosing stress and its impact to teammates.
	1	No impact in caring for the youth at the time of the event.
	2	Stress had an impact on actions/decisions which contributed to the event under review.

FATIGUE MANAGEMENT

Ability to recognize and manage unsafe work practices influenced by extreme tiredness. Professionals experience this tiredness as a result of casework and/or other life circumstances (e.g., single parent, personal illness).

Questions to Consider	Ratings & Descriptions	
• What pressures are you facing, professionally and personally, that contribute to fatigue? Do	0	Clear awareness of the effect of fatigue and demonstrates management strategies. Practices candor in disclosing fatigue and its impact to teammates.

FATIGUE MANAGEMENT

Ability to recognize and manage unsafe work practices influenced by extreme tiredness. Professionals experience this tiredness as a result of casework and/or other life circumstances (e.g., single parent, personal illness).

you awake feeling rested most mornings? Do you practice unhealthy habits (e.g., energy drinks) to mask fatigue?	1	No impact in caring for the youth.
	2	Fatigue had an impact on actions/decisions which contributed to the event under review.

KNOWLEDGE BASE

An absence of knowledge or difficulty activating knowledge (i.e., putting knowledge into practice).

Questions to Consider	Ratings & Descriptions	
• Has working with this youth required you to acquire new knowledge or skills? Do you feel well-versed to provide care to this youth? Do you believe you need additional knowledge to provide optimal, evidence-based care?	0	Clear knowledge base with expertise needed to provide safe, effective, and reliable client care. Aware of applicable evidence-based practices.
	1	No impact in caring for the youth at the time of the event.
	2	Knowledge gaps impacted actions/decisions which contributed to the event under review.

DOCUMENTATION

Presence of official internal records (e.g., case notes, treatment plans, incident reports, shift logging).

Questions to Consider	Ratings & Descriptions	
• If someone only read the notes, would they know what was going on? Is documentation completed within timeframes? Does the logging between shifts give adequate information for the incoming shift? Is the file documentation sufficient for understanding the youth's needs?	0	Exemplar documentation is consistently completed. Documentation is completed within protocol timeframes, with fidelity to any applicable models, and clearly communicates relevant details of case activity, clinical impressions, etc.
	1	No impact in caring for the youth at the time of the event.
	2	Documentation was not completed and/or contains minimal detail which contributed to the event under review.

INFORMATION INTEGRATION

Collection of reports (e.g., assessments, notes) from current or former community providers and/or state agencies.

Questions to Consider	Ratings & Descriptions	
• What have others told you about the youth, their family, and their needs? Have you been able to get historical information on the youth?	0	Clear, comprehensive, and timely information from community and state providers – past and present. The account of the youth's experiences and needs over time are described.
	1	No impact in caring for the youth at the time of the event.
	2	Difficulties obtaining or synthesizing records contributed to the event under review.

TEAM DOMAIN

This section focuses on factors primarily present within teams. Teams include the milieu and clinical staff providing care at the time of the critical incident, as well as their teammates handing off communication to that team (e.g., first shift to second shift; transitions in care, transport, return from passes or outings). The pressures, communication, and climate of the team are considered in this domain, with specific attention given to the supervisors' unique roles in supporting professionals.

Psychological safety is an important team practice, as noted in this domain. While trust is an implicit, personal belief one feels towards others, psychological safety is a shared team practice of 1) demonstrating candor and respect in reporting concerns, 2) transparency, 3) a willingness to report and learn from mistakes, and 4) the provision of collegial support to teammates when others make a mistake or experience an unwanted event. Psychologically safe teams invoke all members to speak up with concerns and practice shared accountability for outcomes.

For the **TEAM DOMAIN,** the item ratings translate into the following categories and action levels:

0	Spread strengths to build sustainability. Monitor as new members come on and new demands emerge.
1	No impact. No action needed.
2	Action likely needed to support goals

PREPARING AND REFLECTING

Team spends time discussing future work activities to identify potential risks and barriers (e.g., huddles, pre-mortem strategies, team briefings). Team spends time reflecting on mistakes, routine practice variability and undesired events to find to ways to learn from them. Team is intentional about learning and practicing psychological safety.

Questions to Consider	Ratings & Descriptions	
• Does the professional team providing youth care routinely gather as a unit? If so, is time taken to project possible risks and barriers? Do all team members contribute as client care is being coordinated?	0	Team demonstrates habit in planning ahead and reflecting back to identify potential risks and barriers. Team is aware of and practices psychological safety.
	1	No impact in caring for the youth at the time of the event.
	2	Trouble with practices around preparing and reflecting back on youth's needs and care contributed to the event under review.

COMMUNICATING EFFECTIVELY

Team effectively disseminates important information through all levels of the organization. Employs strategies (e.g., structured communication tools) for communicating the right information to the right person at the right time.

Questions to Consider	Ratings & Descriptions	
• Do team members know what's going on? When people communicate important information, are distractions minimized? Do teammates use structured communication strategies? Do teammates share a guiding principle of "what do I know and who am I going to tell"?	0	Team demonstrates habit in effectively communicating important information within and across the organization. Team employs structured strategies to enhance communication.
	1	No impact in caring for the youth at the time of the event.
	2	Trouble with communication practices contributed to the event under review.

PROFESSIONALISM

Teams use strategies to intentionally appreciate colleagues and their unique skills. Candor and respect are a precondition to teamwork. Team members share accountability for outcomes.

Questions to Consider	Ratings & Descriptions
• Are team members respectful and candid? Does the team share accountability for the youth's progress and experiences? When conflict occurs, is it within a context of brainstorming and seen as an opportunity to evaluate and consider potential flaws in a plan, or is it taken personally?	0 Team demonstrates habit in managing professionalism. Teams practice exemplary behavior in showing candor and respect to teammates and share accountability for outcomes. Teams demonstrate an intentionally appreciative attitude toward one another. 1 No impact in caring for the youth at the time of the event. 2 Trouble with practices around professionalism contributed to the event under review.

SUPERVISORY SUPPORT

Supervisors provide timely and effective support, direction, communication, and teamwork. Supervisor is intentional about learning and practicing psychological safety.

Questions to Consider	Ratings & Descriptions
• What support has been received from supervisors? What is the leadership style of assigned supervisors? Are they approachable and available? Are supervisors intentional to practice psychological safety?	0 Supervisors are available, approachable, and team-centered. Supervisors understand and practice psychological safety. 1 No impact in caring for the youth at the time of the event. 2 Absent or limited supervisory support contributed to the event under review.

WORKLOAD

The pace of caring for youth's needs safely and consistently, perhaps best described as efficiency demands.

Questions to Consider	Ratings & Descriptions
• Does the team feel pushed by deadlines or ratios? Are staff expectations reasonable to engage in safe and effective, person-centered care? Did the event occur doing moments of increased demands, like coordinating bedtimes or returning from school? How many other situations were staff tending to when the event occurred?	0 Workloads are reasonable and well-managed. Caseloads and other work distributions (e.g., office responsibilities) are routinely at or below the agency's prescribed standard. Team members practice good time management skills and experience resilience with the daily ebb-and-flow of casework. 1 No impact in caring for the youth at the time of the event. 2 Struggles with workload contributed to the event under review.

PRACTICE DRIFT

A broadly-accepted, often gradient, departure from work-as-prescribed. Practice Drift usually occurs as a result of experienced success and as a means of managing workload and/or complex interpersonal decisions. Sometimes described as workarounds or shortcuts.

Questions to Consider	Ratings & Descriptions
• Were workarounds being completed at the time of the event? Were the workarounds or shortcuts common to the particular setting or shift?	0 No evidence of Practice Drift. Quality Improvements processes are lean and agile, so when workarounds occur – the system is examined and resources aligned to steady practice. 1 No impact in caring for the youth at the time of the event. 2 Practice Drift contributed to the event under review.

ENVIRONMENT DOMAIN

This section focuses on factors present in the team's environment, the control factors related to things like physical location, the building, and scheduling. This domain fosters an appreciative inquiry of the team's internal and external access to resources, policies, services, training, and technologies needed to support safe, effective, and reliable care delivery.

For the **ENVIRONMENT DOMAIN,** the item ratings translate into the following categories and action levels:

0	Spread strengths to build sustainability. Monitor as new members come on and new demands emerge.
1	No impact. No action needed.
2	Action likely needed to support goals

AGENCY DEMAND-RESOURCE MATCH

Internal resources or programs (e.g., adequate staffing, crisis response teams, access to drug testing supplies, personal safety materials, safe vehicles, medication administration support) are available to carry out safe, effective, and reliable work practices.

Questions to Consider	Ratings & Descriptions	
• Is the staffing pattern appropriate to meeting youth's basic needs? Do the needed internal agency resources exist for the youth to receive informed clinical care? Does the child have access to the community, outings, etc.? If there is a safety problem, is there a crisis team to offer support?	0	Assigned case professionals had needed resources to carry out safe work practices.
	1	No impact in caring for the youth at the time of the event.
	2	Lack of internal agency resources contributed to the event under review.

AGENCY TECHNOLOGY

Availability of technology (e.g., communication devices, electronics, electronic case record management system) needed to carry out safe, effective, reliable work practices.

Questions to Consider	Ratings & Descriptions	
• How does the current electronic health record management system work? Do professionals have the technology needed to communicate and reach one another efficiently?	0	Equipment and technology are usable, available, efficient, effective, and reliable.
	1	No impact in caring for the youth at the time of the event.
	2	Poor or lack of technology contributed to the event under review.

AGENCY POLICY AND PRACTICE

The presence of clear, effective, accessible, written practice or procedure.

Questions to Consider	Ratings & Descriptions
• How have policies and other formal procedures affected this client's care?	0 Policies are exemplary: clear, effective, available, interpretable, and aligned with best practice. Policy statements are a good balance of concise and thorough.
	1 No impact in caring for the youth at the time of the event.
	2 The absence or ineffectiveness of one or more policies contributed to the event under review.

AGENCY TRAINING

The presence of clear and effective formal instruction.

Questions to Consider	Ratings & Descriptions
• What trainings affected decision-making surrounding this event? Were needed trainings helpful and available?	0 Trainings are clear, effective, available, relatable, pragmatic, and mets or exceeds best practices.
	1 No impact in caring for the youth at the time of the event.
	2 The absence or ineffectiveness of one or more trainings contributed to the event under review.

AGENCY PHYSICAL ENVIRONMENT

The physical setting where youth care occurs, such as a congregate residence, campus, or school.

Questions to Consider	Ratings & Descriptions
• Does the layout contribute to challenges supervising? Are calm spaces present and inviting? Are their windows and visible access to safe, outside spaces?	0 The physical setting meets or exceeds the needs of the population being served by the agency. The environment is clean, inviting, with clear visibility for the milieu. Calm and inviting spaces exist for times when youth need to decompress.
	1 No impact in caring for the youth at the time of the event.
	2 Challenges in the physical environment existed and contributed to the event under review.

COMMUNITY RESOURCES

The community resources where youth resides. Vocational and educational opportunities as well as mental health and physical healthcare exists in the area. There are opportunities for social connections, playful activities (e.g., parks, exercise) and healthy food.

Questions to Consider	Ratings & Descriptions
• Does the layout contribute to challenges supervising? Are calm spaces present and inviting? Are their windows and visible access to safe, outside spaces? Is their access to external agency mobile/on-site crisis supports in an emergency?	0 The community resources meet or exceed the needs of the population being served by the agency.
	1 No impact in caring for the youth at the time of the event.
	2 Challenges in the community existed and contributed to the event under review.

3. SSIT RATING SHEET

CASE ID:				
Abbreviated Rating Summary				
0=Strength		1=No Impact		2=Influence contributed to event under review
Professional Domain	**Influence**			**Narrative**
	0	**1**	**2**	***Required if rating 2***
1. Bias Management	○	○	○	
2. Stress Management	○	○	○	
3. Fatigue Management	○	○	○	
4. Knowledge Base	○	○	○	
5. Documentation	○	○	○	
6. Information Integration	○	○	○	
Team Domain	**0**	**1**	**2**	***Required if rating 2***
7. Planning Forward and Reflecting Back	○	○	○	
8. Effective Communication	○	○	○	
9. Professionalism	○	○	○	
10. Supervisory Support	○	○	○	
11. Workload	○	○	○	
12. Practice Drift	○	○	○	
Environment Domain	**0**	**1**	**2**	***Required if rating 2***
13. Agency Demand-Resource Match	○	○	○	
14. Agency Technology	○	○	○	
15. Agency Policy and Practice	○	○	○	
16. Agency Training	○	○	○	
17. Agency Physical Environment	○	○	○	
18. Community Resources	○	○	○	

4. QUALITY IMPROVEMENT ADVOCACY

Action planning is an important next step in using the SSIT. Across reviews, agencies need to look for themes at the item-level to consider ways to alleviate challenges that contribute to unwanted events. Teams are an important part of agency improvement efforts, as they may create some action steps within their locus of control (e.g., if the team identifies poor communicate strategies at work within the group, they develop a plan to standardize and build some effective communication habits). The domains serve as a prompt to direct action planning as deep into the environment as possible. For example, if the agency's staffing pattern contributes to unwanted events, test changes with the staffing pattern to see if risks can be mitigated. **With time, the goal is for actionable items to transform into strengths.**

Advocating for System Change

Those tasked with event analyses rarely have formal authority to move agencies to change. More often, their success lies in their ability to effectively use data to tell a story and influence communities with such formal authority to move to action. These traits—accurate story-sharing and influence-- are the hallmarks of an effective advocate. QI advocacy, like all forms of advocacy, requires dedicated, experienced individuals armed with information. The SSIT allows a system to standardize important information about its system and to support quality improvement advocacy.