Safe Systems Improvement Tool (SSIT)

2020
REFERENCE
GUIDE

ACKNOWLEDGEMENTS

A large number of individuals have collaborated in the development of the Safe Systems Improvement Tool (SSIT). This information integration tool is designed to support system improvement activities. 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.

The following is a multi-purpose information integration tool designed to be the output of an analysis process. The purpose of this instrument is to support a culture of safety, improvement, and resilience. As such, completion of this instrument is accomplished in order to allow for effective communication at all levels of the system. Since its primary purpose is communication, this instrument is designed based on communication theory rather than the psychometric theories that have influenced most measurement development. 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. Each item uses a 4-level rating (0-3) system. Ratings translate into action levels designed to support quality improvement (QI) activities. For a description of these action levels please see below.
3. Ratings are made to identify an opportunity for improvement independent of a current intervention. If interventions are in place that are masking a need/opportunity, the underlying need/opportunity is described, not its status as a result of the intervention. For example, if a work-around has been created to overcome an equipment failure, the underlying equipment failure should be rated.
4. Item-level ratings are designed to promote objectivity and avoid bias. The potential for implicit and explicit biases should always be considered when rating an item.
5. Ratings use the influences' proximity to the incident as an organizing principle to support communication. If there was closeness in time, distance, or relationship, and with relevance to the incident, a rating of "proximal" (i.e., 3) is appropriate.
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 casework practice. Items are about *relationship and influence* and avoid the controversy of causal assumptions.

This is an effective assessment tool for use in critical incident review (e.g., child fatalities, child near fatalities) but may be used more broadly to understand systemic influences to other outcomes (e.g., youth in foster care being trafficked, children experiencing a long-length of stay in care, maltreatment recurrence). In short, the SSIT provides structure to the output of a review process. It organizes the reviewers' learnings, shares the "system's story" of a critical incident, and advocates for targeted system reform efforts to lessen the likelihood of the problem occurring again in casework. To administer the instrument found at the end of this manual, the reviewer should read the anchor descriptions for each item and then record the appropriate rating on the assessment form.

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 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).

WHAT IS THE SSIT?

IT IS AN IMPROVEMENT STRATEGY

When items are rated with a 2 or 3, they indicate a need for improvement. The SSIT helps a system identify and prioritize systems improvement opportunities. The structure of the SSIT allows a system to uncover those threats/opportunities that are most proximal to adverse events. Quality improvement resources can then be directed efficiently to mitigate risk and support safe, reliable, and effective care.

IT FACILITATES OUTCOMES MEASUREMENT

Ratings on items can be aggregated across cases. The SSIT standardizes critical incident review data for use in quality improvement. SSIT data contributes to professional learning at the individual case level and can be aggregated at any level of the system to support improvement and evaluate change over time.

IT IS A COMMUNICATION TOOL

Classifying complex systems findings into a common language supports improvement discussions at all levels of the organization. SSIT domains, items, and anchors derive from research in human factors and safety science. The SSIT supports organizational learning and an improvement approach focused on human interaction in complex systems.

IT IS A CULTURE CARRIER

The SSIT becomes an important organizational artifact. Use of the SSIT in critical incident reviews reinforces important organizational values and shifts focus away from discussions of blame-worthy acts and simple cause and effect relationships. It supports efforts to create a culture of safety by increasing understanding of complex interactions in tightly-coupled systems.

SSIT BASIC STRUCTURE

The SSIT is organized into four 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 family working with a professional, who works within a team, who all work within an environment. For example, a professional may have experienced trouble interpreting external assessments (e.g., medical records) about a child with complex needs, and which may have been exacerbated by the availability and case direction given by the supervisor. These factors may be further affected by the presence (or lack thereof) of helpful policy, training, and internal professionals who

support the interpretation of medical records. In summary, while the domains provide structure to learning, they are not intended to suggest exclusivity. The intention is of the domains is to guide the reviewer into assessing all system levels.

Child/Family Domain		
Family Conflict	Substance Use	Medical/Physical
Developmental	Financial Resources	Developmental/Intellectual
Mental Health	Supervision	Mental Heath
Professional Domain	**Team Domain**	**Environment Domain**
Bias	Teamwork/Coordination	Demand-Resource Mismatch
Stress	Supervisory Support	Equipment/Technology
Fatigue	Supervisory Knowledge Transfer	Policies
Knowledge Base	Production Pressure	Training
Documentation		Service Array
Evidence		

RATING ITEMS

The SSIT is easy to learn and use in critical incident reviews. It provides structure to organizational learning. The SSIT assesses the underlying factors that influence casework problems. For example, if a critical incident review about a child's unsafe sleep-related death discovers the child welfare professional assigned to the family did not educate on safe sleep practices, the SSIT is designed to support an understanding of the factors that influenced that problem. To use the same example, it is possible the professional co-bedded with his/her own children and therefore undervalued safe sleep practices (SSIT item: Bias), had no policy, training or supervision to support the provision of safe sleep information (SSIT items: Policy, Training, Supervisory Support), and/or did not have external or internal resources to provide the family with a safe sleeping environment (SSIT items: Service Array, Demand-Resource Mismatch).

Improvement Opportunities

It is important to note the SSIT does not identify the problems in the case under review. In this Reference Guide, problems identified in the case under review are called Improvement Opportunities (IOs). These are defined as actions or inactions in the case under review that are either relevant to the outcome (e.g., a child dies abusively at the hands of a caregiver unassessed by the child welfare agency prior to the death) or an important industry standard (e.g., meeting response timeframes for assessing an alleged victim, speaking to collaterals). Systems may use different terms to describe IOs such as learning opportunity, key finding, or observation. The SSIT's ratings are organized around IOs. In order to rate a SSIT as a 2 or 3, the item must be affecting an identified IOs.

The SSIT should be used by someone who is well-versed in their system and current industry standards, acknowledging of the high-risk and complex sociotechnical nature of human service work, and appreciative of the professional's goal to achieve "zero harm" and only the best outcomes.

Like all Transformational Collaborative Outcomes Management (TCOM) tools, the ratings translate into action levels. The SSIT has one retrospective set of action levels for the Family domain, and a prospective set of action levels for the remaining domains.

Scoring the Child and Family Domain

For the Family Domain, the items are rated based on the family's status at the time of the critical incident (Table 1). The family is defined as the child's parents, unless there was another custodial relative or fictive kin caregiver

in which case that person(s) is rated. This means the caregiver rated may not have been the caregiver at the time of the critical incident. If the child was in out-of-home placement (e.g., foster care, legal custody of the child welfare agency) at the time of the critical incident, the family the child was seeking permanency with is rated.

Table 1: Child Family Domain Basic Ratings Design

Rating	Need	Appropriate Level
0	No evidence	No action was needed
1	History	Watchful waiting/prevention was indicated
2	Need interfered with functioning	Action/intervention was needed
3	Need was dangerous or disabling	Immediate action/intensive action was needed

Scoring the System Domains: Proximity

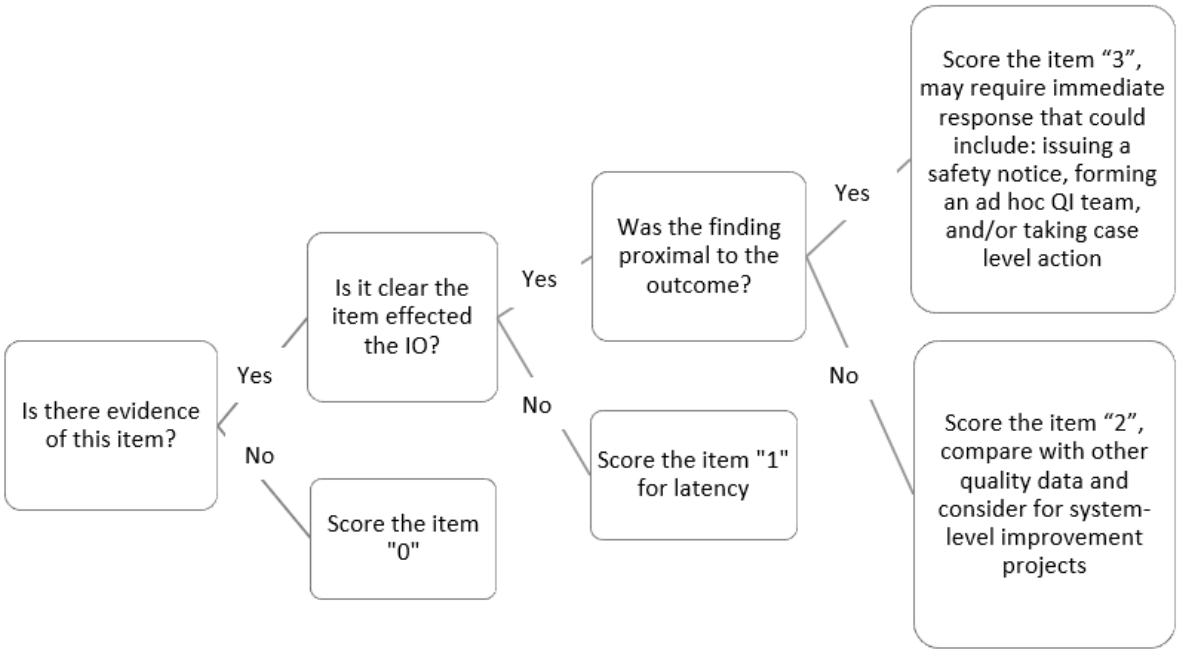
Proximity is used to differentiate between ratings of 2 and 3 (Figure 1) in the 3 system domains – Professional Team, and Environment. Proximity is a Gestalt Principle about how the human mind naturally organizes items. If an IO identified in a case was close in time, distance or relationship to the critical incident and can reasonably be related to the incident, then a rating of proximal (3) is appropriate. For example, if an infant dies in an unsafe sleep environment, and the child welfare agency did not provide safe sleep education and/or timely access to needed safe sleep resources, then SSIT items related to that IO are all scored as proximal (3). Conversely, if an infant dies from a congenital heart condition, yet historical engagement with the household did not include a private interview with all children in the home, all SSIT items related to the IO are scored as non-proximal (2).

Table 2: System Domains Basic Ratings Design

Rating	Observation	Appropriate Action Level
0	No evidence	No action needed
1	Latent factor	Watchful waiting/prevention
2	Non-proximal influence	QI action may be needed to promote best practices in casework. IOs should be tracked over time and/or compared with other quality data before being considered for system-level improvement projects.
3	Proximal Influence	QI action to protect against recurrence of critical incidents may be needed. Response could include: providing case-level or system-wide education or forming an ad hoc QI team.

Scoring in this way promotes rating reliability and secures an understanding of the system-level needs most proximal to critical incidents (Figure 1). While human service agencies are not solely responsible for prevention of critical incident, such organizations are still invested in reducing any and all adverse outcomes as much as possible and in pursuit of “zero harm.”

Figure 1: Scoring Decision Tree



A scoring of ‘2’ or ‘3’ denotes an item as actionable; it means the item affected an IO. 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 every case but also creates a rich database of information over time—allowing for dissection of themes (e.g., common casework barriers, casework problems connected to poor outcomes).

2. SSIT DOMAINS AND ITEMS

FAMILY DOMAIN

This section focuses on factors present in the family at the time of the critical incident. It provides an opportunity to document the family/caregiver and child/youth's needs during the time the critical incident occurred. This domain can be useful in drawing correlations between other domains and certain family items (e.g., if bias correlates to the presence of families with developmental disabilities)

For the **FAMILY DOMAIN,** the item ratings translate into the following categories and action levels, *as they existed at the time of the critical incident* (e.g., death or near death):

0 No evidence; there was no need for action at the time of the critical incident

1 History; there was a need for "watchful waiting" at the time of the critical incident

2 Action was needed at the time of the critical incident

3 Dangerous or disabling problem required immediate and/or intensive action at the time of the critical incident

FAMILY/CAREGIVER ITEMS

FAMILY CONFLICT

This item refers to how much fighting and arguing occurred between family members. Domestic violence refers to physical fighting in which family members might get hurt.

Questions to Consider	Ratings & Descriptions	
• Did members of the family get along well? • Did arguments escalate to physical altercations?	0	Family had minimal conflict, got along well and negotiated disagreements appropriately.
	1	Family generally got along fairly well, but when conflicts arose, resolution was difficult or there was a history of significant conflict or domestic violence.
	2	Family was generally argumentative and significant conflict was a fairly constant theme in family communications.
	3	Family experienced domestic violence. There was threat or occurrence of physical, verbal, or emotional altercations. If the family had a current restraining order against one member, then they would be rated here.

CAREGIVER DEVELOPMENTAL

This item refers to developmental disabilities including autism and intellectual disabilities.

Questions to Consider	Ratings & Descriptions	
• Had the caregiver been identified with any developmental or intellectual disabilities?	0	There was no evidence that the caregiver had developmental needs.
	1	The caregiver had developmental challenges, but they did not currently interfere with parenting or there was a history of those challenges interfering with parenting.
	2	The caregiver had developmental challenges that interfered with their capacity to parent.
	3	The caregiver had developmental challenges that made it impossible for them to parent at the time of the critical incident

CAREGIVER MENTAL HEALTH

This item refers to mental health needs only (not substance abuse). A formal mental health diagnosis is not required to rate this item.
Note: Mental Health Disorders would be rated '2' or '3' unless the individual wa24s in recovery.

Questions to Consider

- Did the caregiver have any mental health needs?
- Were the caregiver's mental health needs interfering with their functioning?

Ratings & Descriptions

0	There was no evidence that the caregiver had mental health needs.
1	The caregiver was in recovery from mental health difficulties or there was a history of mental health problems.
2	The caregiver had mental health difficulties that interfered with their capacity to parent.
3	Caregiver had mental health difficulties that made it very difficult or impossible for them to parent.

CAREGIVER SUBSTANCE USE

This item includes problems with alcohol, illegal drugs and/or prescription drugs.
Note: Substance-Related Disorders would be rated '2' or '3' unless the individual was in recovery.

Questions to Consider

- Did caregivers have any substance use needs that make parenting difficult?
- Did anyone else in the family have a serious substance use need that is impacting the resources for caregiving?

Ratings & Descriptions

0	There was no evidence that the caregiver had any alcohol or drug use problems.
1	The caregiver may have had mild problems with work or home life that result from occasional alcohol or drug use or there is a history of substance use problems.
2	The caregiver had clear problems with alcohol or drug use that interferes with their life, there is a documented history of substance use problems, or the caregiver has a diagnosable substance-related disorder.
3	Caregiver had substance use problems that make it very difficult or impossible for them to parent at this time.

CAREGIVER FINANCIAL RESOURCES

This item rates the family's financial situation.

Questions to Consider:

- Did the caregiver ever struggled financially?
- Did the caregiver ever worried they won't enough money to meet needs?
- What financial challenges did the caregiver have at the time of the critical incident?

Ratings & Descriptions

0	No current need; no need for action or intervention. This may have been a resource for the child. Caregivers had sufficient financial resources to raise the child.
1	Caregiver had some financial resources that actively help with raising the child. History of struggles with sufficient financial resources would be rated here.
2	Need interfered with the provision of care; action is required to ensure that the identified need is addressed. Caregiver had limited financial resources that may be able to help with raising the child.
3	Need prevented the provision of care; required immediate and/or intensive action. Caregiver had no financial resources to help with raising the child. Caregiver needed financial resources.

Supplemental Information: This item reflects whether or not the parent was able to rely on financial resources to support the needs of their child. This does not suggest that the family that was limited in their income did not have strength in this area as they may have demonstrated a strong ability to conserve their spending and stretch their resources. A family that overspent and was left with the inability to meet the financial needs of the child and family would not rate highly in this area. The focus is whether or not the family had the resources to meet the needs of the child and how well this was managed.

CAREGIVER SUPERVISION

This item rates the caregiving behaviors of the primary caretaker(s)

Questions to Consider	Ratings & Descriptions	
• Did caregivers provide developmentally appropriate supervision? • Did caregivers meet the basic caregiving needs of the child, following through on the recommendations of professionals (e.g., physicians, counselors)?	0	Caregiver(s) were involved with child and provide appropriate levels of expectations and supervision for the child.
	1	Caregiver(s) were involved and provide expectations for child. There was some supervision, but parents did not check up on child to ensure compliance.
	2	Caregiver(s) were minimally involved and did not follow through with expectations or provide consistent supervision.
	3	Caregiver(s) were uninvolved and did not provide adequate supervision of child.

CHILD/YOUTH ITEMS

CHILD/YOUTH MEDICAL/PHYSICAL

This item is used to describe the child/youth's current medical/physical health.
Note: Most transient, treatable conditions would be rates as a '1'. Most chronic conditions (e.g., diabetes, severe asthma, HIV) would be rated a '2'. The rating '3' is reserved for life threatening medical conditions.

Questions to Consider	Ratings & Descriptions	
• How was the child/youth's health? • Did the child/youth have any chronic conditions or physical limitations?	0	No evidence that the child/youth had any medical or physical problems, and/or they were healthy.
	1	Child/youth had transient or well-managed physical or medical problems. These include well-managed chronic conditions like juvenile diabetes or asthma.
	2	Child/youth had serious medical or physical problems that required medical treatment or intervention or child/youth had a chronic illness or a physical challenge that requires ongoing medical intervention.
	3	Child/youth had life-threatening illness or medical/physical condition. Immediate and/or intense action was needed due to imminent danger to child/youth's safety, health, and/or development.

CHILD/YOUTH DEVELOPMENTAL/INTELLECTUAL

This item describes the child/youth's development as compared to standard developmental milestones, as well as rates the presence of any developmental (motor, social and speech) or intellectual disabilities. It includes Intellectual Developmental Disorder (IDD) and Autism Spectrum Disorders. Rate the item depending on the significance of the disability and the related level of impairment in personal, social, family, school, or occupational functioning.

Questions to Consider	Ratings & Descriptions	
• Did the child/youth's growth and development seem age appropriate? • Had the child/youth been screened for any developmental problems?	0	No evidence of developmental delay and/or child/youth had no developmental problems or intellectual disability.
	1	There were concerns about possible developmental delay. Child/youth may have low IQ, a documented delay, or documented borderline intellectual disability (i.e. FSIQ 70-85). Mild deficits in adaptive functioning were indicated.
	2	Child/youth had developmental delays (e.g., deficits in social functioning, inflexibility of behavior causing functional problems in one or more settings) and/or mild to moderate Intellectual Disability/Intellectual Disability Disorder. (If available, FSIQ 55-69.) IDD affected communication, social functioning, daily living skills, judgment, and/or risk of manipulation by others.

CHILD/YOUTH DEVELOPMENTAL/INTELLECTUAL

This item describes the child/youth's development as compared to standard developmental milestones, as well as rates the presence of any developmental (motor, social and speech) or intellectual disabilities. It includes Intellectual Developmental Disorder (IDD) and Autism Spectrum Disorders. Rate the item depending on the significance of the disability and the related level of impairment in personal, social, family, school, or occupational functioning.

	3	Youth has severe to profound intellectual disability (FSIQ, if available, less than 55) and/or Autism Spectrum Disorder with marked to profound deficits in adaptive functioning in one or more areas: communication, social participation and independent living across multiple environments.

CHILD/YOUTH MENTAL HEALTH

This item is used to describe the child/youth's mental health (not substance abuse or dependence). A formal mental health diagnosis is not required to score this item.

	Ratings & Descriptions	
Questions to Consider • Did the child/youth have any mental health needs? • Were the child/youth's mental health needs interfering with their functioning?	0	There was no evidence that the child/youth was experiencing mental health challenges. The child/youth had no signs of any notable mental health problems.
	1	The child/youth had mild problems with adjustment, may have been somewhat depressed, withdrawn, irritable, or agitated.
	2	The child/youth had moderate mental health challenges and/or a diagnosable mental health problem that interfered with their functioning.
	3	The child/youth had significant challenges with their mental health. The child/youth had a serious psychiatric disorder.

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 assigned to the case or experiencing the problem under review. 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 for a problem's existence; 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 No evidence, no need for action.

1 Latent factor.

2 QI action may be needed to mitigate risk and avoid recurrence of non-proximal influences.

3 A priority for QI action to prevent recurrence of proximal influences.

BIAS

A faulty understanding of a situation due to inherent predisposition(s) (e.g., confirmation bias, cognitive fixation, focusing effect, transference).

Questions to Consider	Ratings & Descriptions	
• What were your thoughts when you received the referral/case? About the family? Perpetrators? Children?	0	No evidence of bias(es) that impacted objectivity.
	1	Evidence of latency (i.e. no known impact to case, but bias was present).
	2	Bias(es) impacted actions/decisions which affected safety and risk assessment or casework. Actions/decisions were not proximal to poor outcomes.
	3	Bias(es) impacted actions/decisions proximal to poor outcomes.

STRESS

Unsafe work practices influenced by a 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).

Questions to Consider	Ratings & Descriptions	
• What were the pressures you faced, professionally and personally? How did that impact casework? How do you know when you are stressed?	0	No evidence of stress influencing casework practices.
	1	Evidence of latency (i.e. no known impact to case, but stress was present).
	2	Stress had an impact on case events which affected safety and risk assessment or casework.
	3	Stress was proximal to poor outcomes.

FATIGUE

Unsafe work practices influenced by extreme tiredness. Professionals experienced this tiredness as a result of casework and/or other life circumstances (e.g., single parent, personal illness).

Questions to Consider	Ratings & Descriptions	
• What were the pressures you faced, professionally and personally, that contributed to fatigue? How did that impact casework? How much sleep had you received in the days preceding this incident?	0	No evidence of fatigue influencing casework practices.
	1	Evidence of latency (i.e. no known impact to case, but fatigue was present).
	2	Fatigue had an impact on case events which affected safety and risk assessment or casework.
	3	Fatigue was proximal to poor outcomes.

KNOWLEDGE BASE

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

Questions to Consider	Ratings & Descriptions	
• Was there anything you learned from this case that you previously had not known? Were there items you felt unequipped to assess or address? Were any records (i.e., medical records) difficult to interpret?	0	No evidence of knowledge gaps.
	1	Evidence of latency (i.e. no known impact to case, but knowledge gaps were present).
	2	Knowledge gaps impacted actions/decisions and affected safety and risk assessment or casework. Actions/decisions were not proximal to poor outcomes.
	3	Knowledge gaps impacted actions/decisions proximal to poor outcomes.

DOCUMENTATION

Absent or ineffective official records.

Questions to Consider	Ratings & Descriptions	
• If someone only read the notes, would they know what was going on?	0	No evidence of documentation concerns. Documentation was completed within protocol timeframes and clearly communicated relevant details of case activity, case manager impressions, etc.
	1	Evidence of latency (i.e. no known impact to case, but documentation concerns were present)
	2	Essential documentation was not completed and/or available in the hard case file and/or contains minimal detail. Lack of documentation resulted in field professionals not having a clear sense of the relevant details of the case and affected safety and risk assessment or casework. Actions/decisions were not proximal to poor outcomes.
	3	Essential documentation was not completed and/or available in the hard case file and/or contained minimal detail. The extent of documentation issues was proximal to poor outcomes.

EVIDENCE

Difficulties in obtaining and synthesizing (i.e., summarizing; combining multiple pieces of information into a coherent holistic assessment) externally-sourced information (e.g., medical records, criminal records, statements from key members, formal assessments).

Questions to Consider	Ratings & Descriptions	
• How did you decide what records to request in this case? Were historical records on previous services requested? How were assessments used to plan services?	0	No evidence of difficulties in obtaining or synthesizing external records.
	1	Evidence of latency (i.e. no known impact to case, but concerns were present).
	2	Difficulties obtaining or synthesizing records affected safety and risk assessment or casework. Actions/decisions were not proximal to poor outcomes.
	3	Difficulties obtaining, or synthesizing records were proximal to poor outcomes.

TEAM DOMAIN

This section focuses on factors primarily present within teams. The pressures, communication, and climate of the team are considered in this domain, with specific attention given to the supervisor's unique role in supporting the professional. This domain is not exclusive to factors only present among internal teams; collaboration with relevant community partners is assessed as well.

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

0 No evidence, no need for action.

1 Latent factor.

2 QI action may be needed to mitigate risk and avoid recurrence of non-proximal influences.

3 A priority for QI action to prevent recurrence of proximal influences.

TEAMWORK/COORDINATION

Ineffective collaboration between two or more internal and/or external entities (e.g., agencies, people and teams).

Note: Ineffective teamwork between a supervisor and supervisee is captured under "Supervisory Support."

Questions to Consider	Ratings & Descriptions	
• What barriers existed in communicating with outside partners during this case? How often did you communicate? What barriers existed in internal communication while working this case?	0	No evidence of issue with teamwork/coordination.
	1	Evidence of latency (i.e., no known impact to case, but teamwork/coordination concerns were present).
	2	Teamwork/coordination impacted actions/decisions which affected safety and risk assessment or casework. Actions/decisions were not proximal to poor outcomes.
	3	Teamwork/coordination impacted actions/decisions proximal to poor outcomes.

SUPERVISORY SUPPORT

Supervisor provides ineffective support, communication, teamwork, and/or is unavailable.

Questions to Consider	Ratings & Descriptions	
• What support was received from supervisors during this case? What is supervision generally like on this team? What was the supervisor's leadership style?	0	No evidence of problems with supervisory support.
	1	Evidence of latency (i.e., no known impact to case, but supervisory support concerns were present).
	2	Supervisory support problems affected safety and risk assessment or casework—OR—a professional involved in the case disclosed feeling poorly supported by their supervision. Actions/decisions were not proximal to poor outcomes.
	3	Supervisory support problems were proximal to poor outcomes.

SUPERVISORY KNOWLEDGE TRANSFER

Case direction from supervisor was inconsistent with best practice.

Questions to Consider	Ratings & Descriptions	
• What case direction was received from supervisors during this case? Was case direction aligned with best practice?	0	No evidence of problems with supervisory knowledge transfer.
	1	Evidence of latency (i.e., no known impact to case, but supervisory case direction concerns were present).
	2	Supervisory case direction affected safety and risk assessment or casework. Actions/decisions were not proximal to poor outcomes.
	3	Supervisory case direction was proximal to poor outcomes.

PRODUCTION PRESSURE

Demands on professionals to increase efficiency.

Note: This is distinctive from Demand Resource Mismatch (DRM) as Production Pressure describes pressures within casework (e.g., overdues, extensive court involvement, child removals in other assigned cases). Though not exclusively, the presence of DRM may impact the presence of Production Pressures.

Questions to Consider	Ratings & Descriptions	
• How pushed were you by deadlines in this case? How many other cases did you have? What was happening in other cases during the time of this incident?	0	No evidence of problems with production pressures.
	1	Evidence of latency (i.e., no known impact to case but production pressures were present).
	2	Production pressures affected safety and risk assessment or casework. Actions/decisions were not proximal to poor outcomes.
	3	Production pressures were proximal to poor outcomes.

ENVIRONMENT DOMAIN

This section focuses on factors present in the team's environment. 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 and reliable care delivery.

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

0 No evidence, no need for action.

1 Latent factor.

2 QI action may be needed to mitigate risk and avoid recurrence of non-proximal influences.

3 A priority for QI action to prevent recurrence of proximal influences.

DEMAND-RESOURCE MISMATCH

A lack of internal resources or programs (e.g., inadequate staffing, limited access to drug testing supplies, insufficient funding for services) to carry out safe work practices. *Note: The absence of equipment/technology and external resources/programs are scored in separate items.*

Questions to Consider	Ratings & Descriptions	
• What was the staffing pattern at the time of this case? How long has it been that way? What problems did it cause in this case? What is the barrier to having adequate staffing?	0	No evidence of problems with demand-resource mismatch. Assigned case professionals appeared to have needed resources to carry out safe work practices.
	1	Evidence of latency (i.e., no known impact to case, but demand-resource mismatch was present).
	2	Lack of resources to carry out safe work practices affected safety and risk assessment or casework. Actions/decisions were not proximal to poor outcomes.
	3	Lack of resources to carry out safe work practices were proximal to poor outcomes.

EQUIPMENT/TECHNOLOGY

An absence or deficiency in the equipment and technology (e.g., communication devices, electronics, protective safety materials like gloves, vehicles, operability and usability of electronic records management system) used to carry out work practices.

Questions to Consider	Ratings & Descriptions	
• What equipment would have been helpful in this case? Were there any difficulties in acquiring or using certain equipment or technology?	0	No evidence of problems with equipment or technology.
	1	Evidence of latency (i.e., no known impact to case, but issues with equipment/technology were present).
	2	The absence or deficiency of equipment or technology affected safety and risk assessment or casework. Actions/decisions were not proximal to poor outcomes.
	3	The absence or deficiency of equipment or technology was proximal to poor outcomes.

POLICIES

The absence, poor clarity, or ineffectiveness of a written practice or procedure.

Questions to Consider	Ratings & Descriptions	
• What policies, protocols, or forms affected this case? How did it impact decisions? What would have been more helpful?	0	No evidence to suggest absent or ineffective policies influenced the case.
	1	Evidence of latency (i.e., no known impact to case, but the absence of ineffectiveness of a policy was present).
	2	The absence or ineffectiveness of one or more policies affected safety and risk assessment or casework. Actions/decisions were not proximal to poor outcomes.
	3	The absence or ineffectiveness of one or more policies was proximal to poor outcomes.

TRAINING

The absence, poor clarity, or ineffectiveness of formal instruction.

Questions to Consider	Ratings & Descriptions	
• What trainings affected decision-making in this case? Were needed trainings helpful and available? What trainings would have been useful?	0	No evidence to suggest absent or ineffective trainings influenced the case.
	1	Evidence of latency (i.e., no known impact to case, but the absence of ineffectiveness of a training was present).
	2	The absence or ineffectiveness of one or more trainings affected safety and risk assessment or casework. Actions/decisions were not proximal to poor outcomes.
	3	The absence or ineffectiveness of one or more trainings was proximal to poor outcomes.

SERVICE ARRAY

The unavailability or ineffectiveness of a particular external and/or community-based service to support safe, healthy outcomes for clients (e.g. children and families) or staff.

Questions to Consider	Ratings & Descriptions	
• What services are available in the area? How accessible are those services? How effective do services appear to be?	0	No evidence of problems with service array.
	1	Evidence of latency (i.e., no known impact to case, but service array concerns were present).
	2	Problems with service array existed and affected safety and risk assessment or casework. Actions/decisions were not proximal to poor outcomes.
	3	Significant problems with service array existed and were proximal to poor outcomes.

3. SSIT SCORESHEET

CASE ID:					
Abbreviated Rating Summary for Family Domain					
0=No Evidence	1=Minimal Problem or History		2=Problem affected Functioning		3=Severely Disabling or Dangerous Problem
Abbreviated Rating Summary for Professional, Team, and Environment Domains					
0=No Evidence of Influence	1=Latent Factor		2=Evidence of Influence		3=Evidence of Proximity to Poor Outcomes
Family Domain	**Influence**				**Narrative**
	0	**1**	**2**	**3**	***Required if rating is 2 or 3***
1. Family Conflict (Caregiver)	○	○	○	○	
2. Developmental (Caregiver)	○	○	○	○	
3. Mental Health (Caregiver)	○	○	○	○	
4. Substance Use (Caregiver)	○	○	○	○	
5. Financial Resources (Caregiver)	○	○	○	○	
6. Supervision (Caregiver)	○	○	○	○	
7. Medical/Physical (Child)	○	○	○	○	
8. Developmental/Intellectual (Child)	○	○	○	○	
9. Mental Health of (Child)	○	○	○	○	
Professional Domain	**0**	**1**	**2**	**3**	***Required if rating is 2 or 3***
10. Bias	○	○	○	○	
11. Stress	○	○	○	○	
12. Fatigue	○	○	○	○	
13. Knowledge Base	○	○	○	○	
14. Documentation	○	○	○	○	
15. Evidence	○	○	○	○	
Team Domain	**0**	**1**	**2**	**3**	***Required if rating is 2 or 3***
16. Teamwork/Coordination	○	○	○	○	
17. Supervisory Support	○	○	○	○	
18. Supervisory Knowledge Transfer	○	○	○	○	
19. Production Pressure	○	○	○	○	
Environment Domain	**0**	**1**	**2**	**3**	***Required if rating is 2 or 3***
20. Demand-Resource Mismatch	○	○	○	○	
21. Equipment/Technology	○	○	○	○	
22. Policies	○	○	○	○	
23. Training	○	○	○	○	
24. Service Array	○	○	○	○	

Improvement Opportunities (IOs)

4. QUALITY IMPROVEMENT ADVOCACY

In this final section we provide strategies for using SSIT data to share the "system's story" of a critical incident and support advocacy for system improvement actions. A primary purpose of measurement is to cultivate shared language and inform decision-making. For this reason, item ratings within the Professional, Team, and Environment domains translate into the following action levels:

Table 2: System Domains Basic Ratings Design

Rating	Observation	Appropriate Action Level
0	No evidence	No action needed
1	Latent factor	Watchful waiting/prevention
2	Non-proximal influence	QI action may be needed to promote best practices in casework. IOs should be tracked over time and/or compared with other quality data before being considered for system-level improvement projects.
3	Proximal Influence	QI action to protect against recurrence of critical incidents may be needed. Response could include: providing case-level or system-wide education or forming an ad hoc QI team.

SSIT action levels are not intended to be prescriptive. They are a steady and reliable guide for targeting system reform in the areas most likely to prevent a future critical incident. Items scoring "3" translate into a priority for action because the item influenced an IO proximal to a critical incident. Nesting the domains serves as a prompt to direct QI resources as deep into the system as possible, so—if a review yields proximal scores in the Professional, Team, and Environment domains—resources can be directed to improve the Environment, rather than merely providing professionals with directives.

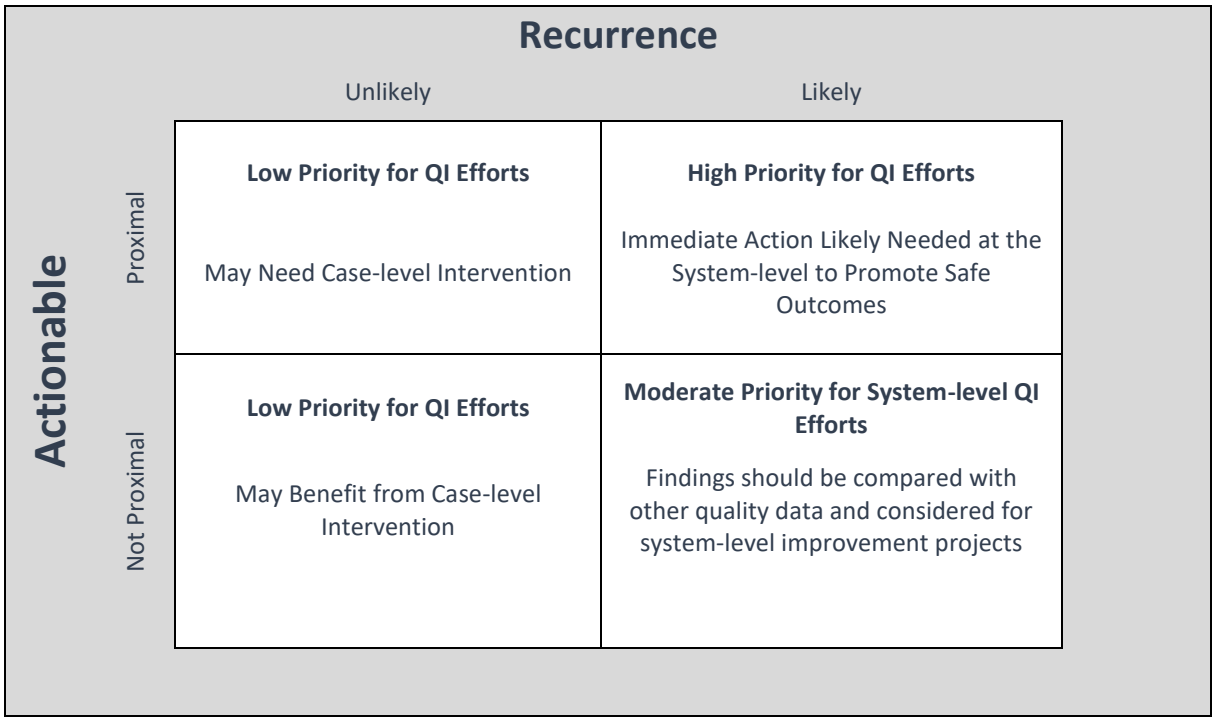
SSIT data can be aggregated and reviewed to inform system-focused quality improvement opportunities. SSIT data should be viewed alongside the IOs from reviewed cases. For example, IOs may reveal inconsistent engagement of all caregivers in a home, allegation/incident-focused casework practice, or barriers in reviewing all applicable case history. Prior to review of SSIT data, it is useful to consider how likely these IOs are to recur in the system. While this can be done through content analysis of IOs as well as a review of other QI data (e.g., Child and Family Service Review findings), the following anchors (table 3) may be helpful in thinking through the likelihood for IOs to recur within a system:

Table 3: Recurrence Rating Structure

ORGANIZATIONAL RECURRENCE	
Questions to Consider • Is this finding already known to be part of a systems issue? • Are effective procedures in place to address? • Have system changes already been in effect since the problem last occurred?	Ratings & Descriptions 0 Minimal or no likelihood of recurrence; problem appears a rare outlier. 1 There is a history of recurrence that appears to have been successfully addressed through organizational improvement(s). 2 There is a likelihood of future recurrence. Though some organizational constructs (e.g., policy, supervision practices, trainings, technology, resource allocation) exist to address the problem, it is unproven or disproven if these will successfully reduce recurrence. 3 Minimal or no organizational constructs currently exist to address the problem.

When considering where to focus finite QI resources, the QI Advocacy Matrix (figure 2) may support decision-making. After establishing recurrence likelihood - and with proximity established by the SSIT - QI professionals can use the matrix to identify and advocate for those IOs that should be prioritized. IOs that are both proximal and likely to recur may require more immediate action form the system (see top right quadrant in table below). IOs likely to recur but not proximal to critical incidents may benefit from system-level QI resources, but it is prudent to compare such findings with other system data so as to make the most informed decision (see bottom right quadrant). IOs unlikely to recur may be suitable for case-level intervention (see left side). For example, a region may have experienced an isolated and/or unusual problem that can be improved by collaborating directly with local region's personnel. The following table is a graphic depiction of this concept:

Figure 2: QI Advocacy Matrix



Advocating for System Change

Those tasked with reviewing critical incidents rarely have formal authority to move systems 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 QI advocacy.