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 that is 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 the 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 five key principles of a communimetric measure that apply to understanding this instrument.

**Six Key Principles**

1. It is designed at the item level. Each item informs the development of a plan. Each item is individually reliable and valid.
2. The numbers associated with the items translate immediately into action levels.
   1. ‘0’ indicates no evidence, no need for action
   2. ‘1’ indicates latent factor
   3. ‘2’ indicates action needed to mitigate risk and avoid reoccurrence
   4. ‘3’ indicates immediate or intensive action required to prevent recurrence
3. The ratings are made for the opportunity for improvement independent of current interventions. So, 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. Culture and development are considered before the action levels are applied. This characteristic is the mechanism to make a common language culturally sensitive and developmentally informed.
5. Items are agnostic as to etiology. The majority of communimetric items are designed to be descriptive and avoid the controversy that can arise from cause-effect assumptions.

This is an effective assessment tool for use in either safety analysis or for use in designing and planning quality improvement projects. To administer the instrument found at the end of this manual, the analyst or other quality improvement personnel should read the anchor descriptions for each item and then record the appropriate rating on the assessment form.

**Item Anchors**

# **Cognitive Fixation**

Definition: A faulty understanding of a situation due to biases (e.g., confirmation bias, focusing effect, transference).

## Influence

|  |  |
| --- | --- |
| 0 | No evidence of biases that impacted objectivity. |
| 1 | Evidence of minor biases that had minimal impact on objective actions/decisions. Problems have or can be addressed with existing policy and/or practice change. |
| 2 | Biases impacted on objectivity/actions/decisions which resulted in an increase in risk for clients and/or staff. Existing policy or practice protocols are insufficient to address these deficits or biases. |
| 3 | Biases led to actions/decisions that created immediate/significant risk for clients and/or staff. No policy or practice protocols exist to address these biases. |

## Reoccurrence

|  |  |
| --- | --- |
| 0 | No evidence to suggest reoccurrence of bias. |
| 1 | Minimal likelihood of reoccurrence if biases are addressed through existing supervision/training. |
| 2 | Similar biases are likely to reoccur. Action is needed to avoid reoccurrence. |
| 3 | Reoccurrence of similar biases is almost certain. Immediate or intensive action is required to prevent reoccurrence. |

# **Demand-Resource Mismatch**

Definition: A lack of resources (e.g., human, capital) to carry out safe work practices.

## Influence

|  |  |
| --- | --- |
| 0 | No evidence of problems with demand-resource mismatch. Worker appeared to have needed resources to carry out safe work practices. |
| 1 | Lack of resources to carry out safe work practices had a minimal influence on casework. |
| 2 | Evidence exists that a lack of or insufficient resources had an impact on case events which resulted in an increase in risk for clients and/or staff and/or an inability to effectively address client needs. |
| 3 | Lack of or insufficient resources created an immediate risk for clients and/or staff, preventing progress towards goals. |

## Reoccurrence

|  |  |
| --- | --- |
| 0 | No evidence to suggest reoccurrence of demand-resource mismatch. |
| 1 | Minimal likelihood of reoccurrence of demand-resource mismatch. |
| 2 | Mismatch between work demands and available resources are likely to reoccur. Action is needed to avoid reoccurrence. |
| 3 | Mismatch between work demands and available resources are almost certain to reoccur. Immediate or intensive action is needed to avoid reoccurrence. |

# **Documentation**

Definition: Absent or ineffective documentation in connection with a particular case.

## Influence

|  |  |
| --- | --- |
| 0 | No evidence of documentation concerns. Documentation was completed within protocol timeframes and clearly communicates needed details of case activity, worker impressions, etc. |
| 1 | Absent or ineffective documentation had a minimal influence in the case. Minimal needed documentation may be absent or have been completed outside of protocol timeframes and/or documentation may not clearly communicate essential details of case activity, worker impressions, plans of action, etc. |
| 2 | Evidence of absent or ineffective documentation of case activity, worker impressions, plans of action, etc. Essential documentation (case notes, safety plans, NCPPs, etc.) not completed in TFACTS or available in the hard case file or contains minimal detail. Lack of or inefficiency of documentation result in supervisors/reviewers not having a clear sense of the details or trajectory of the case by review of TFACTS, case file documentation. |
| 3 | Evidence of absent or ineffective documentation of case activity, worker impressions, plans of action, etc. Essential documentation (case notes, safety plans, NCPPs, etc.) is not completed in TFACTS or available in the hard case file or contains minimal detail. Lack of or inefficiency of documentation result in supervisors/reviewers not having a clear sense of the details or trajectory of the case by review of TFACTS, case file documentation. The extent of documentation issues creates immediate risk for clients and/or staff, preventing progress towards goals. |

## Reoccurrence

|  |  |
| --- | --- |
| 0 | No evidence to suggest reoccurrence of absent or ineffective documentation. |
| 1 | Minimal likelihood of reoccurrence of absent or ineffective documentation. Issues that exist have been addressed through supervision/training. |
| 2 | Absent or ineffective documentation is likely to continue/reoccur. Action is needed to avoid reoccurrence. |
| 3 | Absent or ineffective documentation is almost certain to continue/reoccur. Immediate or intensive action is needed to avoid reoccurrence. |

# **Equipment/Technology**

Definition: An absence or deficiency in the equipment and technology utilized to carry out work practices.

## Influence

|  |  |
| --- | --- |
| 0 | No evidence of problems with equipment or technology. |
| 1 | Equipment/technology had a minimal influence on work practices. Or, there have been a history of problems with equipment/technology that have been addressed through policy/practice change, TFACTS upgrades, etc. |
| 2 | Evidence that the absence of or deficiency in the equipment and technology needed to carry out work practices influenced case events. |
| 3 | The absence of or deficiencies in the equipment and technology needed to carry out work practices had a significant influence on case events, causing immediate risk for clients and/or staff and preventing progress towards goals. |

## Reoccurrence

|  |  |
| --- | --- |
| 0 | No evidence to suggest reoccurrence of equipment/technology deficiencies. |
| 1 | Minimal likelihood of reoccurrence of equipment/technology deficiencies. Issues that exist have been addressed through equipment/technology troubleshooting/upgrades. |
| 2 | Absence of or deficiencies in equipment and technology is likely to continue/reoccur. Action is needed to avoid reoccurrence. |
| 3 | Absence of or deficiencies in equipment and technology is almost certain to continue/reoccur. Immediate or intensive action is needed to avoid reoccurrence. |

# **Teamwork/Coordination**

Definition: Ineffective collaboration between two or more entities (e.g., agencies, people and teams).

## Influence

|  |  |
| --- | --- |
| 0 | No evidence of problems with interfacing or collaborating with other entities involved in the case. |
| 1 | Difficulties with interfacing and collaborating with other entities involved in the case had a minimal influence on case practice. Or, historic problems have existed but have been addressed through policy and/or practice change. |
| 2 | Evidence exists that difficulties interfacing and collaborating with other entities involved in the case had an impact on case events which resulted in an increase in risk for clients and/or staff and/or an inability to effectively address client needs. |
| 3 | Difficulties interfacing and collaborating with other entities involved in the case had a significant influence on case events, creating an immediate risk for clients and/or staff and preventing progress towards goals. |

## Reoccurrence

|  |  |
| --- | --- |
| 0 | No evidence to suggest reoccurrence of interfacing/collaboration difficulties. |
| 1 | Minimal likelihood of reoccurrence of interfacing/collaboration difficulties. Issues that have historically existed have been addressed through policy or practice changes. |
| 2 | Interfacing/collaboration difficulties are likely to continue/reoccur. Action is needed to avoid reoccurrence. |
| 3 | Interfacing/collaboration difficulties are almost certain to continue/reoccur. Immediate or intensive action is needed to avoid reoccurrence. |

# **Knowledge Deficit**

Definition: An absence of knowledge or difficulties activating knowledge (putting it into practice).

## Influence

|  |  |
| --- | --- |
| 0 | No evidence of knowledge deficits. |
| 1 | Evidence of minor knowledge deficits that had minimal impact on actions/decisions. Or, a history of knowledge deficits that have been addressed through supervision or training. |
| 2 | Knowledge deficits impacted on actions/decisions made which resulted in an increase in risk for clients and/or staff. Existing policy, supervision practices/protocols, and trainings are insufficient to address these deficits. |
| 3 | Knowledge deficits led to actions/decisions that created immediate/significant risk for clients and/or staff. No policy, supervision practices or trainings exist to address these deficits. |

## Reoccurrence

|  |  |
| --- | --- |
| 0 | No evidence to suggest reoccurrence of knowledge deficits. |
| 1 | Minimal likelihood of reoccurrence if knowledge deficits are addressed through existing supervision/training. |
| 2 | Similar knowledge deficits are likely to reoccur. Action is needed to enhance supervision and training in order to avoid reoccurrence. |
| 3 | Reoccurrence of similar knowledge deficits is almost certain. Immediate or intensive action is required to prevent reoccurrence. |

# **Medical Records**

Definition: Difficulties in obtaining, understanding and utilizing medical record or autopsy information.

## Influence

|  |  |
| --- | --- |
| 0 | No evidence of difficulties in obtaining, understanding or utilizing medical records or autopsy information. |
| 1 | Difficulties in obtaining, understanding and/or utilizing medical record or autopsy information had a minimal influence on case practice. Or, historic problems have been sufficiently addressed with policy and/or practice change. |
| 2 | Difficulties obtaining, understanding and/or utilizing medical records or autopsy information had an influence on case understanding, decisions and actions which resulted in increased risk for clients and/or staff. |
| 3 | Difficulties obtaining, understanding and/or utilizing medical records or autopsy information had an influence on case understanding, decisions and actions which created an immediate risk for clients and/or staff and prevented progress towards goals. |

## Reoccurrence

|  |  |
| --- | --- |
| 0 | No evidence to suggest reoccurrence of difficulties in obtaining, understanding and/or utilizing medical record or autopsy information. |
| 1 | Minimal likelihood of reoccurrence of difficulties if existing protocols/procedures/supports are utilized. |
| 2 | Similar difficulties in obtaining, understanding and/or utilizing medical record or autopsy information are likely to reoccur. Action is needed to prevent reoccurrence. |
| 3 | Reoccurrence of similar difficulties in obtaining, understanding and/or utilizing medical record or autopsy information are almost certain. Immediate or intensive action in required to prevent reoccurrence. |

# **Policies**

Definition: The absence or ineffectiveness of a policy.

## Influence

|  |  |
| --- | --- |
| 0 | No evidence to suggest that absent or ineffective policies influenced case practice. |
| 1 | The absence or ineffectiveness of policies had a minimal influence on case practice. Or, historical inefficiencies in policy have been addressed through addition of new policies or revisions of existing ones. |
| 2 | Current policies related to case practice are inefficient and resulted in an increase in risk to the client and/or staff. |
| 3 | Absent or inefficient policies had a significant influence on case practice which created an immediate risk for clients and/or staff and prevented progress towards goals. |

## Reoccurrence

|  |  |
| --- | --- |
| 0 | There is no evidence to suggest reoccurrence of absent or inefficient policies. |
| 1 | Minimal likelihood of reoccurrence of absent or inefficient policies provided existing policies are followed and enforced effectively. |
| 2 | Absence and/or inefficiency of policies is likely to reoccur. Action is needed to create new policies or revise existing ones in order to avoid reoccurrence. |
| 3 | Absence and/or inefficiency of policies is almost certain to reoccur. Immediate or intensive action (i.e. creation of new policies or revision of existing ones) is required to prevent reoccurrence. |

# **Production Pressure**

Definition: Demands to increase efficiency, which are incompatible with safety assurance.

## Influence

|  |  |
| --- | --- |
| 0 | No evidence of problems with production pressure impacting on safety assurance. |
| 1 | Production pressure had a minimal influence on case practice. Demands for work efficiency did not appear to increase risk of safety for client or staff. Or, there have been historic problems with production pressures impacting on client/staff safety which have been addressed with policy and/or practice changes. |
| 2 | Evidence exists that production pressures had an impact on case events which resulted in an increase in risk for clients and/or staff and an inability to effectively address client needs. |
| 3 | Production pressures created an immediate risk for clients and/or staff, preventing progress towards goals. |

## Reoccurrence

|  |  |
| --- | --- |
| 0 | No evidence to suggest reoccurrence of production pressures. |
| 1 | Minimal likelihood of reoccurrence of production pressures. team has sufficient staffing resources to manage workload and referral volume, moving forward. |
| 2 | Production pressures are likely to reoccur. Action is needed to enhance staffing resources in order for workload volume to be managed safely and efficiently in order to avoid reoccurrence. |
| 3 | Production pressures are almost certain to reoccur. Immediate or intensive action is required to enhance staffing resources in order for workload volume to be managed safely and efficiently to prevent reoccurrence. |

# **Service Array**

Definition: The availability of a particular service which could support safe environments for children and families.

## Influence

|  |  |
| --- | --- |
| 0 | No evidence of problems with service array. |
| 1 | Minimal problems exist with service array. Needed services that would support safe environment for children and families do exist but may not be as geographically convenient as would be desired. Or, there have been historic problems with service array in the family’s home community that have been addressed/mitigated. |
| 2 | Problems with service array exist. Needed services that would support safe environment for children and families do not exist within the family’s home community/county. Accessing available services farther away presents a burden to the family, decreasing compliance with service plans. |
| 3 | Significant problems with serve array exist. Services that would support safe environment for children and families do not exist anywhere close to the family’s home community or are inaccessible, given the family’s financial resources or insurance providers. These problems create an immediate risk for clients and prevent compliance with service plans and progress towards goals. |

## Reoccurrence

|  |  |
| --- | --- |
| 0 | No evidence to suggest reoccurrence of service array deficits. |
| 1 | Minimal likelihood of reoccurrence of service array deficits. Or historical problems with service array have been addressed through the addition of services/resources in the family’s home community/county. |
| 2 | Service array deficits are likely to reoccur. Action is needed to add to array of services available in and around the family’s home community/county. |
| 3 | Reoccurrence of service array deficits are almost certain. Immediate or intensive action is required to mitigate barriers that prevent the addition of services available in and around the family’s home community/county. |

# **Shared Learning**

Definition: An ineffective transfer of learning between entities (e.g., agencies, people, and teams).

## Influence

|  |  |
| --- | --- |
| 0 | No evidence of problems with shared learning between entities. |
| 1 | Difficulties with shared learning between entities had a minimal influence on case practice and understanding of case dynamics, history, etc. Or, historic problems with shared learning between entities have existed but have been addressed through police and/or practice change or enhanced communication with community partners. |
| 2 | Evidence exists that difficulties with shared learning between entities had an impact on case events and understanding of case history/dynamics which resulted in an increase in risk for clients and/or staff and/or difficulties addressing client needs. |
| 3 | Deficits in shared learning between entities had a significant influence on case events and understanding of case history/dynamics, creating an immediate risk for clients and/or staff and preventing progress towards goals. |

## Reoccurrence

|  |  |
| --- | --- |
| 0 | No evidence to suggest reoccurrence of shared learning deficits. |
| 1 | Minimal likelihood of reoccurrence of shared learning deficits. Issues that have historically existed have been addressed through policy or practice changes and/or enhanced communication with community partners. |
| 2 | Shared learning deficits are likely to continue/reoccur. Action is needed to avoid reoccurrence. |
| 3 | Shared learning deficits are almost certain to continue/reoccur. Immediate or intensive action is needed to avoid reoccurrence. |

# **Stress**

Definition: Unsafe work practices influenced by stress.

## Influence

|  |  |
| --- | --- |
| 0 | No evidence of stress influencing work practices. |
| 1 | Stress had a minimal influence on case practice. While worker appeared to experience some stress related to his/her work on the case, he/she felt equipped to manage that stress. Or, historical problems with stress influencing work practices have been addressed with policy and/or practice changes. |
| 2 | Evidence exists that stress had an impact on case events which resulted in an increase in risk for clients and/or staff and an inability to effectively address client needs. Worker expressed difficulties managing the level of stress that existed during his/her work on the case or that work expectations did not allow for basic needs to be met (adequate sleep and food, reasonable work hours, etc.), thus increasing stress. |
| 3 | Stress created an immediate risk for clients and/or staff, preventing progress towards goals. Worker expressed feeling ill-equipped to manage the level of stress involved in working the case or that work expectations created unsafe working conditions. |

## Reoccurrence

|  |  |
| --- | --- |
| 0 | No evidence to suggest reoccurrence of stress influencing case practice. |
| 1 | Minimal likelihood of reoccurrence of stress influencing case practice. Issues that have historically existed have been addressed through policy or practice changes. |
| 2 | Stress influencing case practice is likely to reoccur. Action is needed (i.e. to create more reasonable work expectations for workers, to address workers’ stress levels, etc.) so that workloads can be managed safely and efficiently in order to avoid reoccurrence. |
| 3 | Stress influencing case practice is almost certain to reoccur. Immediate or intensive action is required (i.e. to create more reasonable work expectations for workers, to address workers’ stress levels, etc.) in order for workloads to be managed safety and efficiently to prevent reoccurrence. |

# **Supervisory Support**

Definition: Ineffective support or knowledge transfer from a supervisor to those supervised.

## Influence

|  |  |
| --- | --- |
| 0 | No evidence of problems with supervisory support. Workers expressed feeling well supported by supervisors and that supervisors are easily accessed, when needed. |
| 1 | Supervisory support had a minimal influence on case practice. Communication with or support from supervisors was generally positive but a few concerns were expressed by workers. Or, historic problems with supervisory support have been addressed with policy and/or practice changes. |
| 2 | Evidence exists that supervisory support had an impact on case events which resulted in an increase in risk for clients and/or staff. Supervisors were not easily accessible by workers in the field to assist with decision making or were experienced as not supporting/empowering field staff. |
| 3 | Supervisory support issues created an immediate risk for clients and/or staff. Supervisors were not available or supportive, leaving field staff to have to make case decisions on their own, without supervisory approval. |

## Reoccurrence

|  |  |
| --- | --- |
| 0 | No evidence to suggest reoccurrence of supervisory support issues. |
| 1 | Minimal likelihood of reoccurrence of supervisory support issues. Historic concerns with supervisory accessibility and support have been sufficiently addressed through policy and/or practice changes. |
| 2 | Issues with supervisory support are likely to reoccur. Tension continues to exist surrounding the level of support worker(s) feel(s) from supervisor(s). Action is needed in order to avoid reoccurrence. |
| 3 | Issues with supervisory support are almost certain to reoccur. Significant unresolved tension exists surrounding the lack of support worker(s) feel(s) from supervisor(s). Or similar concerns have persisted around a lack of supervisory support within a particular team over a period of time. Immediate or intensive action is required to prevent reoccurrence. |

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| |  | | --- | | Influence  0 - No evidence of influence 2 - Evidence of influence on events  1 - Minimal influence 3 - Significant influence  Recurrence  0 - No evidence to suggest reoccurrence 2 - Likely to reoccur  1 - Minimal likelihood of reoccurrence 3 - Reoccurrence almost certain | | | | | | | | | | | | |
|
| **Themes** | **Influence** | | | |  | **Recurrence** | | | | **Narrative (required if rating 2 or 3)** |
|  |
| Cognitive Fixation | 0 | 1 | 2 | 3 |  | 0 | 1 | 2 | 3 |  |
| Demand-Resource Mismatch | 0 | 1 | 2 | 3 |  | 0 | 1 | 2 | 3 |  |
| Documentation | 0 | 1 | 2 | 3 |  | 0 | 1 | 2 | 3 |  |
| Equipment/Technology | 0 | 1 | 2 | 3 |  | 0 | 1 | 2 | 3 |  |
| Teamwork/Coordination | 0 | 1 | 2 | 3 |  | 0 | 1 | 2 | 3 |  |
| Knowledge Deficit | 0 | 1 | 2 | 3 |  | 0 | 1 | 2 | 3 |  |
| Medical Records | 0 | 1 | 2 | 3 |  | 0 | 1 | 2 | 3 |  |
| Policies | 0 | 1 | 2 | 3 |  | 0 | 1 | 2 | 3 |  |
| Production Pressure | 0 | 1 | 2 | 3 |  | 0 | 1 | 2 | 3 |  |
| Service Array | 0 | 1 | 2 | 3 |  | 0 | 1 | 2 | 3 |  |
| Shared Learning | 0 | 1 | 2 | 3 |  | 0 | 1 | 2 | 3 |  |
| Stress | 0 | 1 | 2 | 3 |  | 0 | 1 | 2 | 3 |  |
| Supervisory Support | 0 | 1 | 2 | 3 |  | 0 | 1 | 2 | 3 |  |