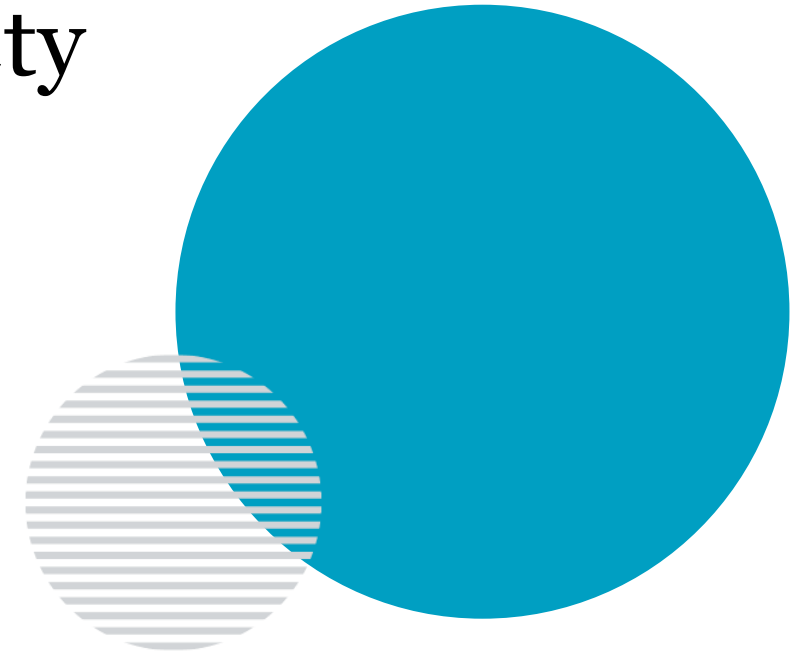
Self-Assessment Tool

A National Action Plan to Advance Patient Safety

The **Institute for Healthcare Improvement** convened the **National Steering Committee for Patient Safety** as a collaboration among 27 national organizations committed to advancing patient safety.



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About the National Steering Committee for Patient Safety

The Institute for Healthcare Improvement convened the National Steering Committee for Patient Safety as a collaboration among 27 national organizations committed to advancing patient safety. IHI gratefully acknowledges the organizations and individual members who contributed their time, expertise, and insight to develop the National Action Plan to Advance Patient Safety and that have committed to advancing the recommendations outlined in this work.

For more than 25 years, the Institute for Healthcare Improvement (IHI) has used improvement science to advance and sustain better outcomes in health and health systems across the world. We bring awareness of safety and quality to millions, accelerate learning and the systematic improvement of care, develop solutions to previously intractable challenges, and mobilize health systems, communities, regions, and nations to reduce harm and deaths. We work in collaboration with the growing IHI community to spark bold, inventive ways to improve the health of individuals and populations. We generate optimism, harvest fresh ideas, and support anyone, anywhere who wants to profoundly change health and health care for the better. Learn more at ihi.org.

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Self-Assessment Tool: A National Action Plan to Advance Patient Safety

This self-assessment is complementary to the recommendations and tactics presented in *Safer Together: A National Action Plan to Advance Patient Safety* (National Action Plan) and the accompanying Implementation Resource Guide.[1,2] The assessment is organized by the four interrelated foundational areas, described in the National Action Plan, for developing a total systems approach to advance patient safety: Culture, Leadership, and Governance; Patient and Family Engagement; Workforce Safety; and Learning System. The self-assessment questions represent a selection and synthesis of elements detailed in the complete National Action Plan and may, therefore, provide a partial representation of the current state of an organization's patient safety efforts.

The self-assessment is primarily intended for health care delivery organizations to use as a tool for organizational learning and to track the progress of safety improvement efforts over time. The assessment is not meant to serve as a comprehensive review of an organization's safety program or culture, nor is it intended for comparisons or benchmarking among organizations. Review the National Action Plan and Implementation Resource Guide for detailed recommendations.

Instructions

Before beginning this self-assessment, it is recommended that you read *Safer Together: A National Action Plan to Advance Patient Safety* (National Action Plan).

1. Establish an interdisciplinary team within the organization that will work together to implement the recommendations of the National Action Plan.
2. Organizations may complete this assessment tool as a team or choose to have team members review the information independently, and then come together to discuss their responses.
3. Once the assessment is complete and has been reviewed, the team develops an action plan for improvement, including the identification of roles and responsibilities.
4. The team then plans regular meetings or connection points for follow-up, review, and revisions to their action plan, as necessary.

Assess and Score

- For each row in the tables that follow, **select the statement that best represents** (or is most reflective of) the current state of your organization's safety efforts based on your individual or team's perspective. For any item where there may be uncertainty, consult with colleagues to gain more information and insight to determine the best response.
- In each row, for each selected statement, write the corresponding score number (noted in the column header) in the **Row Score** box.
  For example, if the team selected "Safety goals developed. Some goals are accompanied by an action plan and associated metrics." in the first row of the Culture, Leadership, and Governance section, write a "1" in the Row Score box.
- The **Total Score** is the sum of the Row Scores for each section.

Interpret Score Results

- Use the **Interpreting the Total Score** matrix for each section to determine the current state of your organization's safety efforts and recommended actions to advance patient safety. Based on the recommended actions, the interdisciplinary team develops an improvement plan with clear action steps and metrics.
- In determining where to start, it may be helpful to review the rows with the lowest scores. Note ideas in the **Opportunities for Improvement** section below the matrix.
- For additional information on the recommendations and related resources, refer to the National Action Plan and accompanying Implementation Resource Guide.

Culture, Leadership, and Governance

	SCORE: 1	SCORE: 2	SCORE: 3	SCORE: 4	ROW SCORE
Safety Goals	Safety goals are developed. Some goals are accompanied by an action plan and associated metrics.	Safety *goals are clearly articulated in strategic and operational plans. Each goal* is accompanied by an action plan and associated metrics.	Safety goals are clearly articulated in strategic and operational plans *for all care settings***.** Each goal is accompanied by an action plan and associated metrics.	Safety goals are clearly articulated in strategic and operational plans for all settings of care. Each goal *has a dedicated senior sponsor* and is accompanied by an action plan and associated metrics.	
Job Descriptions	Job descriptions for senior leaders reference responsibility for quality and safety.	Job descriptions for senior leaders *specify explicit responsibility* for quality and safety.	Job descriptions for senior leaders *and trustees* specify explicit responsibility for quality and safety.	Job descriptions for senior leaders and trustees specify explicit responsibility for quality and safety. *Performance reviews for senior leaders include safety and culture metrics.*	
Annual Reviews	Annual reviews of some leaders include a focus on safety.	Annual reviews for *all* senior leaders *incorporate review of organization-wide safety and culture metrics*.	Annual reviews for all senior leaders *and trustees* incorporate review of organization-wide safety and culture metrics, *safety competency assessments, and development plans for education and training in safety and improvement methods.*	Annual reviews for all senior leaders and trustees incorporate review of organization-wide safety and culture metrics, including equity and diversity, safety competency assessments, and development plans for education and training in safety and improvement methods. *Senior leaders and/or trustees are sponsors for patient safety improvement initiatives.*	
Just Culture and Transparency	The organization has a written policy establishing just culture and transparency practices.	The organization has a written policy establishing just culture and transparency practices *that has been adopted in some but not all areas of the organization*.	The organization has a written policy establishing just culture and transparency practices. This policy is adopted by *all areas* of the organization and *training is provided to all clinicians and staff*.	The organization has a written policy establishing just culture and transparency practices. This policy is understood by all clinicians and staff and *includes an audit and reporting program to ensure equal deployment across all areas and levels of the organization.*	
Harm Events	Harm events and reported near misses are reviewed periodically, but not consistently.	All harm events and reported near misses are reviewed and evaluated *in a timely manner. The CEO is notified within 24 hours of a serious adverse event*.	All harm events and reported near misses are reviewed and evaluated in a timely manner. The CEO *and Board Chair* are notified within 24 hours of a serious adverse event.	All harm events and reported near misses are reviewed and evaluated in a timely manner. The CEO and Board Chair are notified within 24 hours of a serious adverse event. *Patient and family communication is completed in accordance with best practices.*	
Meeting Agendas	Safety is not on all leadership and board meeting agendas.	Safety is a topic *included on all* leadership and board meeting agendas.	*At least 20% of all leadership and board meeting agendas* are dedicated to review and discussion of safety.	At least 20% of all leadership and board meeting agendas are dedicated to review and discussion of safety. *There is follow-up on action plans*.	

	SCORE: 1	SCORE: 2	SCORE: 3	SCORE: 4	ROW SCORE
Safety Culture Surveys	No or some units/departments conduct patient safety culture surveys.	An *organization-wide* patient safety culture survey occurs *at least every 2 years using a validated survey tool*.	An organization-wide patient safety culture survey occurs at least every 2 years using a validated survey tool. *Survey data is tracked and trended with the ability to drill down to the unit/department level. Action plans are put in place on an inconsistent basis.*	An organization-wide patient safety culture survey occurs at least every 2 years using a validated survey tool. Survey data is tracked and trended with the ability to drill down to the unit/department level. *Action plans are put in place as a result of the data and progress is monitored and evaluated for improvement. Data and actions are shared at all organization levels*.	
				TOTAL SCORE: **Culture, Leadership, and Governance**	

Interpreting the Total Score: Culture, Leadership, and Governance

For more information on the recommended actions and related resources, please refer to the Implementation Resource Guide.

Total Score	Current State Description	Recommended Actions
7–11	Just Beginning	• Create an action plan for and use improvement science methods to begin improvement in lowest scoring area(s). • Add patient safety improvement to the responsibilities of all leaders. • Create an explicit plan for the entire organization to practice transparency in sharing data and communications. • Add a patient story to start each board and executive meeting, with examples of what has gone well and what can be improved.
12–17	Making Progress	• Assign each senior leader responsibility to lead specific patient safety improvement initiatives, meeting with the team regularly and supporting all efforts. • Develop a plan to ensure that all senior leaders are trained and understand the principles of patient safety. • Create a written just culture policy that clearly applies to all levels and staff in the organization. • Escalate all serious events to the senior level and chairman of the board within 24 hours of occurrence. • Dedicate a portion of every meeting agenda to the discussion of patient safety issues.
18–23	Significant Impact	• Senior leaders, with support and advice from staff, set the goals and strategic plan for the organization. • Incorporate patient safety goals into the strategic plan. Each goal should have a clear aim, interventions to be tested, and associated measures to assess progress toward aims. • Assess all leaders, at all levels of the organization, for progress in fostering a culture of safety and work toward patient and workforce safety goals, with the purpose of reflection and recalibration as needed. • Develop a clear aim and action plan to address all safety issues and defects discussed during meetings.
24–28	Exemplary Performance	• Move from proactive to generative in the approach to patient safety, clarifying that safety is not a project but a way of working. • Ensure all leaders and staff at every level of the organization feel clear ownership for patient safety. • Implement an adverse event review process that begins with and focuses on a review of systems. • Clearly identify the role of the board and senior executives in reviewing and overseeing patient outcomes. • Communicate with staff about their individual roles in improving patient safety, including working as a team to improve the system and ensuring reliable processes that support evidence-based care.

Opportunities for Improvement

Patient and Family Engagement

	SCORE: 1	SCORE: 2	SCORE: 3	SCORE: 4	ROW SCORE
Patient and Family Advisory Council (PFAC)	The organization does not have a Patient and Family Advisory Council or the role of the PFAC is very limited.	The organization *has* a Patient and Family Advisory Council. The organization does not have a mechanism to measure the impact of this work.	The organization has an *actively engaged* Patient and Family Advisory Council. *Senior leaders ensure the PFAC informs an organization- or system-wide strategy and measurement plan for patient engagement*.	The organization has an actively engaged Patient and Family Advisory Council. Senior leaders ensure the PFAC informs an organization- or system-wide strategy and measurement plan for patient engagement *that includes patient and community representation on all boards and committees, event review processes, and improvement initiatives*.	
Co-Design Care with Patients	Some clinicians fully involve patients in their care.	Some clinicians involve patients in their care, *including use of "What matters to you?" questions, checklists, and shared decision-making tools. Some clinicians complete huddles and shift changes at the bedside.*	*All clinicians are trained* to involve patients in their care, including use of "What matters to you?" questions, checklists, and shared decision-making tools. *The organization recommends* completing all huddles and shift changes at the bedside.	*All clinicians fully involve patients* in their care, including use of "What matters to you?" questions, checklists, and shared decision-making tools. *All huddles and shift changes are completed at the bedside.*	
Training and Resources	The organization does not provide safety and patient-provider communication training and resources to patients, clinicians, and staff.	There is *limited* safety and patient-provider communication training. *Resources are available to all patients, clinicians, and staff. These educational materials are available in some of the preferred languages of patients*.	*The organization provides* safety and patient-provider communication training and resources to all patients, clinicians, and staff. These educational materials are *available in the preferred language of each patient.*	The organization provides safety and patient-provider communication training and resources to all patients, clinicians, and staff. These educational materials are available in the preferred language *and appropriate literacy level* for each patient.	
Patient Portals	Patients do not have timely and full access to medical records and visit notes.	Patients *have access* to their medical records through an online portal. There is not an organizational program to ensure that all patients know about and are able to access their records.	Patients have access to their medical records through an online portal. *There is an organization-wide program to raise awareness about patient ability to access their medical records and advisors are available to assist patients as needed*.	Patients have *timely and full* access to medical records *and visit notes* through a *user-friendly* online portal. There is an organization-wide program to raise awareness about patient ability to access their medical records and advisors are available to assist patients as needed. *The organization monitors patient activity on this platform to understand use and usability, and fosters increasing use by all patients.*	

	SCORE: 1	SCORE: 2	SCORE: 3	SCORE: 4	ROW SCORE
Equity	The organization does not segment and review adverse event data and patient experience feedback by characteristics such as race, ethnicity, sexual orientation, gender, age, disability, and income.	The organization *understands the need* to segment and address adverse event data and patient experience by different patient segments and *has begun to identify the data necessary for this review*.	The organization *segments and reviews* all adverse event data and patient experience feedback by characteristics such as race, ethnicity, sexual orientation, gender, age, disability, and income. *Senior leaders regularly review identified gaps, and action plans to address health inequities are developed and executed*.	The organization segments and reviews all adverse event data and patient experience feedback by characteristics such as race, ethnicity, sexual orientation, gender, age, disability, and income. Senior leaders regularly review identified gaps, and action plans to address health inequities are developed and executed. *All leaders, clinicians, and staff receive training in health equity and unconscious bias.*	
Communication and Resolution for Adverse Events	The organization does not have a communication and resolution program (CRP) to respond to adverse events.	The organization *has made a commitment* to a communication and resolution program (CRP) to respond to adverse events, but has not made it organizational policy.	The organization *has a communication and resolution program (CRP)* to respond to adverse events. *All staff are trained in appropriate response to adverse events.*	The organization has a communication and resolution program (CRP) and a staff training plan in place to respond to adverse events. *Support programs are available for patients and families, clinicians, and staff who are impacted by these events. The program is regularly reviewed by senior leaders and the board.*	
Escalation Pathways for Safety Events	There is no mechanism for patients and families to report safety events outside of the complaint system.	*Patients have the ability to report safety events into a patient safety database*, though the system may be variable across the organization.	Patients have the ability to report safety events into a patient safety database, and there is a *structured system for patients and families to escalate concerns about their care through the use of a rapid response team or other structured response mechanism*.	Patients have the ability to report safety events into a patient safety database, and there is a structured system for patients and families to escalate concerns about their care through the use of a rapid response team or other structured response mechanism. *The organization regularly reviews and responds to safety events that have been raised by patients and families*.	
				TOTAL SCORE: **Patient and Family Engagement**	

Interpreting the Total Score: Patient and Family Engagement

For more information on the recommended actions and related resources, please refer to the Implementation Resource Guide.

Total Score	Current State Description	Recommended Actions
7–11	Just Beginning	• Establish a Patient and Family Advisory Council (PFAC), learning from others how to optimize engagement with this council to understand what matters to patients. • Teach all care delivery staff and others in the organization the importance of engaging with patients in developing their treatment plans. • Investigate data available to assess equity in care delivery.
12–17	Making Progress	• Demonstrate the importance of engaging patients and families through leadership behaviors. • Include discussions between patients and leaders during walkarounds. • Develop measures that provide information on the success and impact of engaging the PFAC in improvement activities. • Provide information for patients at the appropriate literacy level. • Identify how to use existing data to explore inequities and add new segments as needed to ensure all patients are considered. • Include patients and human factors experts when designing a portal for patients to access their medical information.
18–23	Significant Impact	• Teach clinicians how to ensure transparency when offering treatment choices to patients and work to understand what matters to all patients. • Ensure digital literacy and access so that patients can access their medical information through a portal. • Take actions specifically focused toward the goal of ensuring equitable care and treatment for all patients and staff. • Segment staff data when examining equity for patients and the workforce. • Commit to and build the appropriate infrastructure to support a communication and resolution program to respond to adverse events.
24–28	Exemplary Performance	• Counsel leaders and staff to model patient-centered thinking by asking the question, “What will this mean for the patient?” prior to making any changes or decisions. • Ensure the organization’s PFAC is consulted in any improvement efforts and in policy developments. • Create and implement a plan to ensure that all patients have access to their medical records and can navigate the patient portal for personal information, clinical notes, and communication with the care team. • Fully implement a communication and resolution program, offering support for patients, families, and clinicians involved in an adverse event.

Opportunities for Improvement

Workforce Safety

	SCORE: 1	SCORE: 2	SCORE: 3	SCORE: 4	ROW SCORE
Job Descriptions	Job descriptions and performance expectations for leaders do not reflect accountability for workforce safety.	Job descriptions and performance expectations *for some leaders reflect accountability for workforce safety*.	Job descriptions and performance expectations for *all leaders* reflect accountability for workforce safety.	Job descriptions and performance expectations for all leaders reflect accountability for workforce safety. *In addition, the organization has appointed designated leaders to champion and drive improvement in workforce safety.*	
Safety Strategy	The organization does not yet have an explicit workforce safety strategy.	The organization *has an explicit workforce safety strategy*, but it is not aligned with the mission and patient safety strategy.	The organization has an explicit workforce safety strategy *that is aligned with the mission and patient safety strategy*.	The organization has an explicit workforce safety strategy that is aligned with the mission and patient safety strategy. *This strategy includes a multi-year work plan, metrics, and a well-understood reporting protocol.*	
Occupational Safety	The organization does not consult with occupational safety experts and does not have a system to capture and control job hazards by position.	The organization *periodically consults* with occupational safety experts and is *working to ensure the development of* a system to capture and control job hazards by position.	The organization *regularly consults* with occupational safety experts to ensure the development of a system to capture and control job hazards by position.	The organization *employs and fully integrates* occupational safety experts to ensure the development *and use of* a system to capture and control job hazards by position.	
Budgeting	Organizational and department budgets are not designed to address resources for staff safety, including equipment, systems, and personnel.	Organizational and department budgets *reflect adequate resources for staff safety, including equipment, systems, and personnel.*	Organizational and department budgets reflect adequate resources for staff safety, including equipment, systems, and personnel. *These budgets are reviewed by senior leaders.*	Organizational and department budgets reflect adequate resources for staff safety, including equipment, systems, and personnel. These budgets are reviewed *and championed* by senior leaders.	
Safety Reporting System	The organization does not have a workforce safety reporting system.	The organization *has a workforce safety reporting system* to identify physical harm.	The organization has a workforce safety reporting system *that allows for anonymous reporting by employees and staff, physical and psychological harm, and captures (control) job hazards by position*.	The organization has *an integrated patient and workforce safety system* that allows for reporting of *physical and psychological events of harm and anonymous reporting by all employees/staff and patients and families*. *The system includes stratification of sociodemographic data, evaluation of and plans to identify inequities, and monitoring and evaluation to foster meaningful action to address inequities*.	

	SCORE: 1	SCORE: 2	SCORE: 3	SCORE: 4	ROW SCORE
Priority Safety Programs	The organization tracks several or all of the following priority programs: slips/trips/falls prevention, safe patient handling, exposures, sharps injuries, and violence prevention.	The organization tracks the following priority programs: slips/trips/falls prevention, safe patient handling, exposures, sharps injuries, and violence prevention. *The organization has developed an action plan to respond when an injury occurs.*	*Action plans for workforce safety include metrics and are developed for some departments*. The organization tracks the following priority programs: slips/trips/falls prevention, safe patient handling, exposures, sharps injuries, violence prevention, *and psychological safety*.	Action plans for workforce safety include metrics and are developed and implemented *for all departments*. At a minimum, these plans include the following priority programs: slips/trips/falls prevention, safe patient handling, exposures, sharps injuries, violence prevention, and psychological safety.	
Safety Events	Workforce safety is discussed only when there is a serious safety event.	The organization *engages in intermittent communication with staff* about workforce safety hazards, incident rates, safety stories, and actions taken to improve workforce safety.	The organization engages in *frequent communication* with staff about workforce safety hazards, incident rates, safety stories, and actions taken to improve workforce safety.	The organization is *fully transparent* about and engages in *regular communication with staff* about workforce safety hazards, incident rates, safety stories, and actions taken to improve workforce safety.	
				TOTAL SCORE: Workforce Safety	

Interpreting the Total Score: Workforce Safety

For more information on the recommended actions and related resources, please refer to the Implementation Resource Guide.

Total Score	Current State Description	Recommended Actions
7–11	Just Beginning	• Adopt the explicit aims to embrace workforce safety as a core value and eliminate harm to the workforce. Develop plans and allocate budgets and human resources for workforce safety. • Identify where any workforce safety data currently resides, and who collects and reports on key OSHA metrics. Identify occupational health leaders and establish a plan for conducting a gap analysis of the current state. • Conduct a business case/ROI for workforce safety in alignment with leadership, occupational health, human resources, finance, and safety/risk leaders. • Assess whether current reporting systems have the capability for reporting workforce injury and illness. • Benchmark workforce safety strategies, practices, and systems. • Establish a plan to conduct workforce safety surveys.
12–17	Making Progress	• Assign accountability for creation and monitoring of workforce safety dashboards for presentation to leaders and trustees and include in job descriptions. Integrate workforce safety dashboards into leadership and board meetings. • Conduct workforce and workplace safety surveys and communicate data and actions across the organization. • Develop a plan to capture and stratify workforce safety data by position and sociodemographic factors. Identify and implement a workforce safety reporting system that has the capability to collect stratified data. • Implement organization-wide training on policies and processes for reporting physical and psychological harm events. • Incorporate appropriate responsibilities for workforce safety in all job descriptions.
18–23	Significant Impact	• Assess all candidates for hiring, contracting, and promotions for evidence of workforce safety commitment and practices. • Ensure that all leaders, managers, and staff are aware of workplace safety statistics and related actions taken to address and reduce harm. • Align patient and workforce safety with harm reduction goals and strategies. • Ensure that organizational and local-level workforce safety initiatives consistently monitor for and address inequities related to physical and psychological harm. • Engage community services as part of de-escalation and workplace violence strategies.
24–28	Exemplary Performance	• Ensure plans for workforce safety are embedded in all succession strategies and related requirements prioritize workforce safety. • Share experiences in organized learning networks to enable scale-up of successful practices across other organizations. • Speak and publish on pathways to mature a culture of workforce safety and workforce safety systems and practices. • Articulate the business case for workforce safety to external audiences. • Identify, monitor, and address workforce harms from inequities.

Opportunities for Improvement

Learning System

	SCORE: 1	SCORE: 2	SCORE: 3	SCORE: 4	ROW SCORE
Harm Events	Harm events and reported near misses are reviewed periodically, but not consistently. Voluntary and anonymous reporting is sporadic.	The *organization follows up on serious harm events*, but lessons learned are not shared with the entire organization.	The organization has *clear processes in place in some areas to evaluate and learn from near misses and safety events*, including voluntary and anonymous reporting systems *available to all staff and defined event review processes*.	The organization has clear processes in place to evaluate and learn from near misses and safety events *across the organization*, including voluntary and anonymous reporting systems available to all staff, defined event review processes, *and audit systems*.	
Patient Engagement	There is no process to engage patients and families and/or their involvement in learning systems is discouraged.	*Less than one quarter* of the areas of the organization engage patients and families in learning systems and feedback processes.	The organization includes patient and family representatives in *at least half* of all learning systems and feedback processes.	The organization includes patient and family representatives in *all* learning systems and feedback processes.	
Event Review	Organizational leaders are not involved in event investigations. Information is not shared and transparency is discouraged.	*Clinical leaders* are involved in event investigations. *Information is shared in the involved department/service only.*	Clinical leaders are involved in event investigations. Information is shared in the involved department/service *and learnings are communicated to staff*. There are *some examples of improvement spurred by reported events*.	Clinical leaders are involved in event investigations. Information is shared in the involved department/service and learnings are *regularly* communicated to *all* staff. *All team members can share examples of improvements spurred by reported events*.	
Education and Competencies	There is no clearly defined strategy for patient safety competencies or education within the organization.	*Select staff members* in select departments receive basic patient safety education as a part of their role within the organization.	The organization's *documented human resources strategy includes a defined patient safety curriculum and competencies for clinical roles* and evaluations to assess these competencies. *Action plans for continuing education are limited to leaders and clinicians*.	The organization's documented human resources strategy includes a defined patient safety curriculum and competencies for *all* roles, regular evaluations to assess these competencies, and action plans for continuing education of *all leaders, clinicians, and staff*.	
Learning Networks	The organization does not participate in learning networks.	Although the organization is a member of a learning network, *participation is limited*.	The organization *has started actively participating* in a system-wide and/or external learning network that shares data and established best practices. *The organization has developed a plan to integrate this learning*.	The organization *actively participates* in a system-wide and/or external learning network that shares data and established best practices. *The organization integrates this learning in an ongoing way*.	
Safety Goals	The organization's goals are vague and do not specify patient safety.	The organization's goals *include specific patient safety goals*, but targets are not bold. There is no formal process to collect best practices, but rather a reliance on staff willingness to report back from meetings and other outside sources.	The organization has *specific patient safety goals, shares learning, and incorporates evolving evidence-based best practices* with the aim of eliminating specific types of harm and improving safety.	The organization *adopts bold national goals*, shares learning, and incorporates evolving evidence-based best practices with the aim of eliminating specific types of harm and improving safety.	
				TOTAL SCORE: Learning System	

Interpreting the Total Score: Learning System

For more information on the recommended actions and related resources, please refer to the Implementation Resource Guide.

Total Score	Current State Description	Recommended Actions
6–10	Just Beginning	• Intentionally work to develop trust and psychological safety to improve reporting of safety issues. • Design investigations into adverse events to include clinical leaders and others to ensure a larger system view. • Learn from other health systems how patient safety has been incorporated into their strategic plans. • Emphasize that patients must be engaged in investigation of all adverse events. Use simulation to learn how to best engage patients.
11–15	Making Progress	• Ask leaders to share data and decision-making processes as a step toward building transparency and a culture of safety. • Investigate both adverse events and near misses to learn about a systems approach to understanding and addressing contributing factors. • Provide all staff with basic training in patient safety, taking advantage of existing curricula. • Set bold targets focused on being the best, rather than just better than benchmark. • Join networks of like-minded organizations (e.g., patient safety organizations, like-sized hospitals, groups of hospitals with similar specialties) to share lessons learned and learn from others. • Collect data and review with experts in data management, analyzing trends and variation. • Develop a culture of transparency by sharing results of investigations and changes to be tested in a way that does not violate patient privacy or jeopardize discovery protections.
16–20	Significant Impact	• Lead with humility, asking those who do the work to help address defects and improve patient safety. • Continue to expand the role of patients and families in improvement efforts. • Provide all leaders with the opportunity to gain the data analysis skills needed to determine opportunities for improvement. • Dedicate a quality board for each clinical area around which staff and leaders meet to discuss progress and defects that must be addressed.
21–24	Exemplary Performance	• View and share adverse events and near misses as learning opportunities, ensuring all improvement decisions are driven by data. • Audit use of data to ensure it is employed appropriately for improvement and accountability. • Use tools such as RCA[2] and FMEA to understand system-level issues. • Plan for staff development to include training and awareness of safety issues and the methods to address identified defects. • Assign individuals to monitor for changes in science/evidence and processes that will impact the organization.

Opportunities for Improvement

[1] National Steering Committee for Patient Safety. *Safer Together: A National Action Plan to Advance Patient Safety*. Boston: Institute for Healthcare Improvement; 2020. http://www.ihi.org/SafetyActionPlan

[2] National Steering Committee for Patient Safety. *Implementation Resource Guide: A National Action Plan to Advance Patient Safety*. Boston: Institute for Healthcare Improvement; 2020. http://www.ihi.org/SafetyActionPlan