1. From the Top:
The Role of the Board in Quality and Safety
A Self Assessment©

Instructions

This self-assessment tool has been developed to assist Board Members, Non–Exec and Senior Leaders in gaining a deeper understanding of their organization's capacity to build a culture of quality and safety. There are no right or wrong responses to this brief survey. It has been designed to obtain data but more importantly it has been designed to create the foundation for dialogue amongst Board members and organizational leaders.

It is recommended that this survey be administered to Board members at the beginning and end of the year in order to gauge progress against a baseline on the six things all boards should do to improve quality and reduce harm.

For each of the items listed on the following pages, you should record the **one response** which best captures the **Current Status** of each item within your organization. There are three responses to consider:

1 = Not in place, which means:
- We haven't discussed it to my knowledge
- I'm unaware that we do anything like this
- We've talked about it, but haven't acted on it
- We used to do this, but we've stopped the practice

2 = Just beginning, which means:
- I think we're planning to do this, but I'm not sure
- We've tried it once or twice but it isn't a regular routine
- We are in the process of doing this, but it isn't complete
- We've started this, but it isn't working very well, in my view

3 = Established practice, which means:
- We have adopted this as a regular process or policy
- We do this at every Board or committee meeting
- We have finalized this, and communicated it to all Board members
- We do this very well
- This activity is part of the very fabric of our work

Thank you very much for your time and dedication to quality and safety improvement.

From the Top:
The Role of the Board in Quality and Safety
A Self Assessment

Date: _____

Organization: _____

For each of the items listed below, please select the one response which best captures your opinion on the statement. The response choices are:

1 = Not in place
2 = Just beginning
3 = Established practice

The specific items are grouped according to the six categories of things that all Boards should do to improve quality and reduce harm.

Setting Aims to reduce harm this year:

My organization has an explicit Aim Statement related to reducing harm this year (e.g., "We will reduce hospital-acquired infections by 50% by 12 months from now, on our way toward our ultimate goal of zero hospital-acquired infections.")	1	2	3
We have publicly declared this Aim Statement (e.g., it is posted publicly, given to patients upon admission and published in our annual report)	1	2	3
We have established specific measures related to this Aim Statement (e.g., "We will know whether we are reducing hospital acquired infections by measuring the total number of ventilator pneumonias, central line infections, MRSA infections, and surgical site infections of specific types, each month)	1	2	3
Each unit or department has established their own Aim Statements designed to reduce harm this year in their area in support of our organization-wide aim	1	2	3

Getting Data and Hearing Stories about the impact of harm:

The topic of reducing harm and improving quality is the first item on the Board's agenda	1	2	3
We review measures related to patient safety and harm at every Board meeting	1	2	3
At every Board meeting we hear the story of at least one incident that caused harm to a patient	1	2	3
The Board chair has commissioned an initial chart audit (with a minimum of 20 patient charts from the previous month) to determine the extent of harm in our care delivery system	1	2	3
When a patient safety event has occurred, the CEO or the CMO takes the lead in conducting an in-depth and thorough root cause analysis of the incident	1	2	3
The CEO or the CMO personally present the results of the in-depth root cause analysis on a patient safety event to the board	1	2	3

Establishing, Monitoring and Displaying System Level Measures:

Our organization has identified a small set of key "high level" quality and safety measures (i.e., a dashboard of whole systems measures)	1	2	3
The measures on our dashboard are well-understood by the whole Board	1	2	3
The measures on our quality and safety dashboard are timely (no more than a month old) when presented to the Board	1	2	3
The same dashboard presented to the Board is regularly shared with all staff	1	2	3
The same dashboard presented to the Board is regularly shared with patients, families and the public	1	2	3
The Board asks as many hard questions about the quality and safety dashboard as it asks about the financial reports	1	2	3

Changing the Environment, Policies and Culture:

This organization aggressively works to maintain an environment that is respectful, just and fair for all those who experience pain, harm or loss as a result of avoidable harm 1 2 3

The Board has approved policies to assure that all staff members know that they can report an error or a patient harm incident without fear of reprisal 1 2 3

The Board has adopted policies and procedures that clearly describe what the Board expects to happen when a sentinel event, or other serious incident of patient harm occurs. (Communication to family, apology, communication to Board, support of staff…etc.) 1 2 3

The Board has regular conversations with the Medical Staff leadership to ask about what the Medical Staff is doing to help achieve the organization's quality and safety goals 1 2 3

The Board has sent a clear signal to administrative, nursing, and medical leaders that it is serious about safety policies, and expects them to be followed 1 2 3

The Board has sent a clear signal that all staff who are working to uphold those policies will be supported, *all the way to the Board.* 1 2 3

Learning…starting with the Board:

We have a good system for educating all Board members so that they clearly understand their responsibilities and accountabilities for clinical quality and safety 1 2 3

All Board members are expected to attend at least basic training in concepts and principles of quality improvement and safety 1 2 3

All Board members can describe the current levels of quality and safety within this organization (i.e., they have reviewed the high level measures and can at least describe our baseline performance) 1 2 3

All Board members can explain or describe the model or framework used at this organization to drive quality and safety (e.g., six sigma, lean, Deming, Juran, Baldrige, etc.) 1 2 3

The Board regularly is exposed to learning from organizations (in or outside of healthcare) that are viewed as benchmarks in the area of quality and patient safety 1 2 3

The Board has approved and resourced a strong plan to build the knowledge and skills of staff (both clinical and non-clinical) in the areas of quality and safety 1 2 3

Establishing Executive Accountability:

The Board has made it very clear to the senior management team that they are expected to achieve results: (i.e. the aims of reducing harm and increasing patient safety adopted by the Board)	1	2	3
Executive performance reviews and their compensation packages are directly tied to the achievement of measured quality and safety results	1	2	3
There is as much weight assigned in the executive compensation program to quality and safety performance as there is to financial performance	1	2	3

2. Assessing Organizational Capacity for Quality Improvement

For each item, you should make two responses. First, indicate the Current Status of each item within your organization by marking one of the following responses:

- Completed (C)
- In Process (IP)
- Not Started (NS)

Then, assign what you believe will be your Future Priority for each item over the coming twelve months by marking one of the following responses:

- High (H)
- Moderate (M)
- Low Priority (L)

Capacity Building Issue	Current Status			Future Priority		
	C	IP	NS	H	M	L
1. Evaluating your organization's mission, vision and values to make sure that they are consistent with QI principles.						
2. Educating the following groups in the theory and tools of QI: • The Board • Senior leaders • Managers • Physicians • Staff	 ___ ___ ___ ___ ___	 ___ ___ ___ ___ ___	 ___ ___ ___ ___ ___	 ___ ___ ___ ___ ___	 ___ ___ ___ ___ ___	 ___ ___ ___ ___ ___
3. Restructuring your performance evaluation system so that it supports your efforts in quality improvement.						
4. Working with suppliers to establish long-term partnerships that are based on collaborative efforts to improve quality.						
5. Providing employees with the support and resources they need to participate in QI teams and work.						
6. Setting up process improvement teams.						
7. Creating a process to set priorities for selecting quality improvement initiatives.						
8. Developing performance indicators of quality improvement initiatives.						
9. Preparing communication tools that share information on quality goals and initiatives with all associates.						

©R. Lloyd. *Quality Health Care: A Guide to Developing and Using Indicators.*

Jones & Bartlett Publishers, Sudbury, MA, 2004.

3. IHI Improvement Capability Self-Assessment Tool

IHI Improvement Capability Self-Assessment Tool:
GUIDE FOR USERS

Hospital leaders and staff can use the IHI Improvement Capability Self-Assessment Tool in several ways:
- To better understand your hospital's improvement capability;
- To stimulate discussion about areas of strength and weakness; and
To help you reflect on and evaluate specific improvement efforts.

Note that this tool is not intended for performance management, judgment, or blame if you determine that your hospital's improvement capability is less than you would like it to be.

You can use the tool to assess your hospital's capability in six key areas: 1) Leadership for Improvement, 2) Results, 3) Resources, 4) Workforce and Human Resources, 5) Data Infrastructure and Management, and 6) Improvement Knowledge and Competence.

For each of these six areas, the tool provides a brief description of levels of capability, ranging from Just Beginning, to Developing, to Making Progress, to Significant Impact, to Exemplary. For each of the six areas, select and record below the level of capability that you think best fits your hospital's current improvement capability – and briefly describe the data/evidence you used to inform your choice.

DIRECTIONS FOR USE

1. For each of the six areas, select and record below the level of capability that you think best fits your hospital's current improvement capability – and briefly describe the data/evidence you used to inform your choice.

2. **Reflect on the results of your assessment:**
- Does your assessment suggest one or more specific actions you can take soon to increase your hospital's capability? Note these
actions and who you would need to collaborate with to move ahead.
- Does your assessment suggest a need for more information to help you determine specific actions to increase your hospital's
capability? Note these needs.

IHI Improvement Capability Self-Assessment Tool
Summary Sheet

	Just Beginning	Developing	Making Progress	Significant Impact	Exemplary	Please provide a brief description of the type of data or other evidence you used to inform your choice.
1. Leadership for Improvement						
2. Results						
3. Resources						
4. Workforce and Human Resources						
5. Data Infrastructure and Management						
6. Improvement Knowledge and Competence						

IHI IMPROVEMENT CAPABILITY SELF-ASSESSMENT TOOL:

The levels below are intended to provide a basic indication of the improvement capability of your hospital in a number of domains that are associated with overall improvement success. This information is confidential; the more honest the assessment, the more likely the initiatives selected will be aligned with current ability and probability of success.

Science of Improvement Self-Assessment

Developed by Dr. Robert Lloyd, Vice President
Institute for Healthcare Improvement

Just Beginning	Developing	Making Progress	Significant Impact	Exemplary
Data Infrastructure and Management: The capability of a hospital to establish, manage, and analyze data for improvement in a timely and routine manner to meet the objectives and expected results of the hospital's improvement plan				
The hospital uses data to measure performance, but only a few places use data to support and inform improvement activities. There is limited ability to communicate information across systems.	The hospital uses data to measure performance and to support some improvement work. The hospital is aware of a need to establish effective data systems to communicate across key stakeholders and partners.	The hospital uses data to measure performance and to support most improvement projects. The hospital has established a number of data systems to allow for some cross-system measures.	The hospital uses data to measure performance and to support almost all improvement projects. The hospital has established a number of data systems which it uses routinely to share system-of-care performance information across key partners and stakeholders.	The hospital uses data to drive all improvement measures at both the whole system and sub-system level. Data systems allow for highly effective communication within and across departments and with key stakeholders in a manner that informs the knowledge and actions required to meet the objectives of improvement teams.
Improvement Knowledge and Competence: The capability of a hospital to obtain and execute on the skills and competencies required to undertake improvement throughout the hospital				
Few if any quality improvement projects are under way that are guided by an organization-wide improvement framework and model. The hospital provides training in improvement methods to staff in a limited fashion.	A number of quality improvement projects are underway. Multidisciplinary teams are formed and actively engaged.	A number of quality improvement projects have achieved measureable improvements.	A number of quality improvement projects have achieved sustained improvement. The hospital spreads learning from quality improvement projects systematically across the organization.	The hospital has embedded quality improvement in all areas of the organization. Teams have achieved and sustained measureable improvements. The hospital consistently shares and spreads improvements across all departments and with key stakeholders.

4. Science of Improvement Self-Assessment

Developed by Dr. Robert Lloyd, Vice President
Institute for Healthcare Improvement

Introduction

This self-assessment is designed to help you gain a better understanding of where you personally stand with respect to your knowledge of the basic principles and tools of the Science of Improvement (SOI). Your responses will help you design your own learning plan. In addition, you can share this assessment with others you work with and start to design a collective strategy for building improvement capacity and capability within your work area. In short, this assessment will help you and those you work with figure out what it will take to make quality improvement part of daily work.

The place to start is to be honest with yourself and see how much you know about quality improvement concepts and methods. There are no right or wrong responses to the statements in this assessment. There is just an opportunity for reflection and discussion.

Your responses to this first administration of the self-assessment will serve as a baseline. We will ask you to complete the assessment periodically to help you evaluate your progress. Thanks in advance for taking the time to complete this assessment.

Instructions

This self-assessment is divided into six skill categories. These skills are referred to as the "Skills to Support Improvement" and serve as the foundation for much of what we teach in our improvement science programmes.

Each of the skill areas is listed below with key concepts and tools that demonstrate knowledge of and ability to apply the concepts. For each concept or tool select the one response that best describes your skill level. The response options are:

A I have no knowledge of this concept/tool.

B I have heard of this concept/tool but could not explain it or apply it.

C I have a working knowledge of this concept/tool and could at least explain what it is.

D I have a working knowledge of this concept/tool and could explain how to apply it if there was someone with deeper knowledge in the room to back me up.

E I have a solid working knowledge of this concept/tool and could demonstrate how to apply it to daily work.

F I am confident and comfortable in explaining, applying, and teaching this concept/tool.

Skills to Support Improvement	Response Options					
1. Supporting a Change with Data						
• Develop a family of measures (i.e., process, outcome and balancing measures)						
• Build clear and unambiguous operational definitions for measures						
• Develop practical data collection plans						
• Construct and interpret a run chart						
2. Developing a Change						
• Decide how much change is actually needed (e.g., do you merely need to reduce variation in the process or fundamentally create a new process through redesign?)						
• Apply Deming's ideas about systems thinking to an improvement opportunity						
• Use driver diagrams to define the system of interest and theories on how the system works						
• Use flowcharting techniques to break a system down into the numerous processes that define how work gets done						
• Identify specific ideas that we believe will achieve the results we desire						
• Handle difficult conversations when individuals express opposing views						
3. Testing a Change						
• Design, set up, and run PDSA cycles (i.e., tests of change)						
• Run tests on a small scale initially and then increase the scale and scope of testing as learning occurs						
• Develop qualitative and/or quantitative data collection plans for the PDSA cycle						
4. Implementing a Change						
• Explain why implementing a change is fundamentally different from testing a change						
• Developing new structures and procedures to support the implemented change (e.g., training, new policies and procedures, job descriptions, or new equipment)						
• Create measurement systems to determine if the improvements observed during the testing stage have been sustained during implementation						
5. Spreading a Change						
• Distinguish clearly how testing, implementing, and spreading a change are all different steps in the sequence of improvement						
• Explain adoption and diffusion principles						
• Build communication strategies that foster and support spread						
6. The Human Side of Change						
• Organize effective team meetings (e.g., setting agendas, assigning team meeting roles such as recorder and time keeper, and establishing ground rules for behavior)						
• Model behaviors that reflect active listening						

Science of Improvement Self-Assessment

Finally, how confident do you feel you are at applying the above concepts/tools to improvement efforts within your work area?
__ Very Confident ___Somewhat Confident __ Unsure __ Not Very Confident __ Absolutely no Confidence

Please use the following space to identify the ***things that are promoting quality improvement efforts*** within your organisation.

Please use the following space to identify the ***things that are holding back quality improvement efforts*** within your organisation

5. Quality Measurement Self-Assessment Tool

This quality measurement self-assessment is designed to help quality facilitators and improvement team members gain a better understanding of where they personally stand with respect to the milestones in the Quality Measurement Journey (QMJ). What would your reaction be if you had to explain why it is preferable to plot data over time rather than using aggregated statistics and tests of significance? Can you construct a run chart or help a team decide which measure is more appropriate for their project?

You may not be asked to do all of the things listed below today or even next week. But if you are facilitating a QI team or expect to be able to demonstrate improvement, sooner or later these questions will be posed. How will you deal with them?

The place to start is to be honest with yourself and see how much you know about concepts and methods related to the QMJ. Once you have had this period of self-reflection, you will be ready to develop a learning plan for yourself and those on your improvement team.

Select the one response which best captures your opinion on each item:

1. I'd definitely have to call in an outside expert to explain and apply this topic/method.
2. I'm not sure I could apply this appropriately to a project.
3. I am familiar with this topic but would have to study it further before applying it to a project.
4. I have knowledge about this topic, could apply it to a project but would not want to be asked to teach it to others.
5. I consider myself an expert in this area, could apply it easily to a project and could teach this topic/method to others.

Measurement Topic or Skill	Response Scale				
	1	2	3	4	5
Help people in my organization determine why they are measuring (improvement, judgment or research)					
Move teams from concepts to specific quantifiable measures					
Building clear and unambiguous operational definitions for our measures					
Develop data collection plans (including stratification and sampling strategies)					
Explain why plotting data over time (dynamic display) is preferable to using aggregated data and summary statistics (static display)					
Explain the differences between random and non-random variation					
Construct run charts (including locating the median)					
Explain the reasoning behind the run chart rules					
Interpret run charts by applying the run chart rules					
Explain the statistical theory behind Shewhart control charts (e.g., sigma limits, zones, special cause rules)					
Describe the basic 7 Shewhart charts and when to use each one					
Help teams select the most appropriate Shewhart chart for their measures					
Describe the rules for special cause variation on a Shewhart chart					
Help teams link measurement to their improvement efforts					

6. Measurement Self Assessment Tool

Developed by
Robert C. Lloyd, Ph.D.

Instructions

Improving the quality of clinical outcomes, customer service and operational efficiencies are key concerns of quality improvement teams. Unfortunately, measurement is where improvement teams often break down. One of the major roles for facilitators is to help teams and individuals address the challenges posed by performance measurement. Yet, facilitators have varying degrees of experience, knowledge and interest in the theory and tools needed to successfully complete the quality measurement journey.

This self-assessment is designed to help facilitators gain a better understanding of where they **personally** stand with respect to explaining or demonstrating various measurement topics and tools. What would your reaction be if you had to explain enumerative versus analytic studies? Can you construct a deployment flow chart? You may not be asked to do all of the things listed below today or even next week. But, if you are facilitating a team or advising a manager on how to evaluate a process improvement effort, sooner or later these questions will be posed. How will you deal with them?

The place to start is to be honest with yourself and see how much you know about measurement. Once you have had this period of self-reflection, you will be ready to develop a learning plan for self-improvement and advancement.

The measurement issues listed below cover two major categories: **theoretical topics**, and **tools/ techniques**. Because you need to be able to blend theory and technique together to be truly successful at measurement, I have not divided the items into categories. The order of the items follows the steps you would typically follow in conducting any improvement initiative.

For each item, use the scale shown on the next page to record your response. While some of the items do have right or wrong answers, many of them are open to interpretation. What you have to do is to determine the level of expertise you wish to have in the measurement area, figure out which topics/tools you need to understand more thoroughly, and then outline a plan for how you will reach this goal. I will be glad to assist any of you in developing a personal measurement learning plan. So, have fun and be honest with yourself!

Topic/Tool	Response

Scale

1	**I could teach this topic to others!**
2	**I could do this by myself right now but would not want to teach it!**
3	**I could do this but I would have to study first!**
4	**I could do this with a little help from my friends!**
5	**I'm not sure I could do this!**
6	**I'd have to call in an outside expert!**

Explain the "quality measurement journey" (i.e., when does measurement begin and when does it end?)	1	2	3	4	5	6
What are quality characteristics (QCs) and why should I be concerned about them?	1	2	3	4	5	6
What is the difference between the voice of the customer and the voice of the process? How are they related?	1	2	3	4	5	6
How do I select one KQC out of all possible QCs?	1	2	3	4	5	6
Construct and explain a Pareto chart	1	2	3	4	5	6
What's the difference between a block and top-down flow chart? When do you use each one? Do you have to use one before the other?	1	2	3	4	5	6
Can you make and explain a detailed flow chart?	1	2	3	4	5	6
How are you at critiquing a detailed flow chart?	1	2	3	4	5	6
Can you construct a value added flow chart?	1	2	3	4	5	6
Can you make a deployment flow chart?	1	2	3	4	5	6
What are the major components of a data collection plan?	1	2	3	4	5	6
Explain the difference between a simple random sample and a stratified random sample.	1	2	3	4	5	6
How do you use a random number table?	1	2	3	4	5	6
Make a presentation on understanding variation.	1	2	3	4	5	6
Who cares about the difference between enumerative and analytic studies? Do I care?	1	2	3	4	5	6
So, what's wrong with collecting data for a day and using this to understand the variation in a process?	1	2	3	4	5	6

Topic/Tool	**Response**

Scale:

1 I could teach this topic to others!
2 I could do this by myself right now but would not want to teach it!
3 I could do this but I would have to study first!
4 I could do this with a little help from my friends!
I'm not sure I could do this!
5 I'd have to call in an outside expert!

Show a team how to construct a run chart.	1	2	3	4	5	6	
Where do the four run tests come from?	1	2	3	4	5	6	
Why do 6 data points constantly increasing (or decreasing) constitute a trend? This seems like a lot of data to me. Why not 3 or 4 data points in a row?	1	2	3	4	5	6	
Can you explain the difference between common and special causes of variation? Give examples?		1	2	3	4	5	6
Why can't I improve a process that contains special causes? Aren't we supposed to make things better? Now you tell me I can't until I get rid of these @*/?^@ special causes!	1	2	3	4	5	6	
QC, KQC, PV, KPV - it all sounds like an alphabet soup to me! Who cares and why are you being so compulsive about making me follow this "quality roadmap?" I can tell you what is wrong with the process. Why do I need to go through all of this. It is wasting time!	1	2	3	4	5	6	
How do you know when to use a control chart?	1	2	3	4	5	6	
What is the difference between variables and attributes data?	1	2	3	4	5	6	
What is a subgroup and how would I know one if I tripped over it?	1	2	3	4	5	6	
When do I use a u-chart? A c-chart?	1	2	3	4	5	6	
What is a "sigma" any way? And how does it differ from a standard deviation?	1	2	3	4	5	6	
Why do we use + /- 3 sigma limits? Why not 2? Or 2.75 sigma units?	1	2	3	4	5	6	
Can you determine when data are normally distributed? If the data are not normally distributed, can you proceed with making a control chart?	1	2	3	4	5	6	
Can you explain why (or why not) you can (or cannot) make a control chart on an individual employee's performance?	1	2	3	4	5	6	

7- Transparency Assessment Tool

Level of Transparency	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
1. Greater transparency is needed across all healthcare settings and providers.					
2. Patients should be able to compare hospitals as easily as they do cars and other products.					
3. Results on hospital outcomes (mortality, infections, falls, med errors, etc.) should be made public ***once a year.***					
4. Results on hospital outcomes (mortality, infections, falls, med errors, etc.) should be made public ***twice a year.***					
5. Results on hospital outcomes (mortality, infections, falls, med errors, etc.) should be made public ***four times a year.***					
6. Results on groups of doctors (surgeons, GPs, intensivists, dentist, etc.) should be made public ***once a year***.					
7. Results on individual doctors should be made public ***once a year***.					
8. All clinical outcomes on hospital performance should be made available to the public.					
9. Operational outcomes on hospital performance (wait times, referral times, access) should be made available to the public.					
10. Patient satisfaction results for each hospital should be made available to the public.					
11. Financial results (including salaries) for each hospital should be made available to the public .					
12. Mortality rates for individual surgeons should be made available to the public.					

13. Infection rates for individual physicians should be made available to the public.					
14. Errors and harm rates for individual physicians should be made available to the public.					
15. Salaries of individual physicians should be made available to the public.					

8- Survey Inventory Worksheet

Column 1 **Short Title of the Survey**	**Column 2** **Target group for the survey**	**Column 3** **Is this survey a:** • Commercial Survey (CS)? • Internal (*ad hoc*) Survey (IS)?	**Column 4** **Frequency of distribution** • A one-time survey (OTS) • A repeat survey? (RS)	**Column 5** What method is used to collect the survey responses (e.g., mailed, telephone, handout, interview)	**Column 6** How many individual questions are on this survey?	**Column 7** How do you intend to use the survey results
		CS IS	OTS RS			
		CS IS	OTS RS			
		CS IS	OTS RS			
		CS IS	OTS RS			
		CS IS	OTS RS			
		CS IS	OTS RS			
		CS IS	OTS RS			

9 - Quality as a Business Strategy assessment tool

Instructions: For each of the Five Quality as a Business Strategy (QBS) Activities listed below select the one response which best captures the current status of the activity within your organization.

Quality as a Business Strategy Five Activities for Leaders	Response Options		
	1	2	3
1. Establishing constancy of purpose in the organization (mission, vision and values)			
2. Viewing the organization as a system			
3. Designing and managing a system for gathering information for improvement			
4. Conducting planning for improvement and integrating it with business planning			
5. Managing and learning from a portfolio of improvement initiatives			

Response Options

1 = Not Started Yet 2 = In progress 3 = Completed and firmly in place

10 - The primary drivers of improvement

Key Components*	Self-Assessment
• Will (to change)	• Low Medium High
• Ideas	• Low Medium High
• Execution	• Low Medium High

*All three components MUST be viewed together. Focusing on one or even two of the components will guarantee sub-optimized performance. Systems thinking lies at the heart of QI!