Improving Patient Safety in Nursing Homes: A Resource List for Users of the AHRQ Nursing Home Survey on Patient Safety Culture

Purpose

This document contains references to Web sites that provide practical resources nursing homes can use to implement changes to improve patient safety culture and patient safety. This resource list is not exhaustive, but is provided to give initial guidance to nursing homes looking for information about patient safety initiatives. This document will be updated periodically.

How To Use This Resource List


For easy access to the resources, keep the file open rather than printing it in hard copy because the Web site URLs are hyperlinked and cross-referenced resources are bookmarked within the document.

NOTE: The resources included in this document do not constitute an endorsement by the U.S. Department of Health and Human Services (HHS), the Agency for Healthcare Research and Quality (AHRQ), or any of their employees. HHS does not attest to the accuracy of information provided by linked sites.

Suggestions for tools you would like added to the list, questions about the survey, or requests for assistance can be addressed to: SafetyCultureSurveys@westat.com.

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TeamSTEPPSTM Rapid Response Systems (RRS) Training Module
TeamSTEPPSTM Readiness Assessment Tool
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The Joint Commission: Patient Safety
Trigger Tool for Measuring Adverse Drug Events in the Nursing Home
Try This: Best Practices in Nursing Care to Older Adults
University of Michigan Health System Patient Safety Toolkit: Disclosure Chapter, NEW
VA National Center for Patient Safety – NCPS Root Cause Analysis Tool
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Why Not the Best?, NEW
Will It Work Here?: A Decisionmaker’s Guide to Adopting Innovations
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1. 2012 National Healthcare Disparities Report
   http://nhqrnet.ahrq.gov/inhqrdr/reports/nhdr

   This report is featured on the Agency for Healthcare Research and Quality’s Web site. The purpose of the National Healthcare Disparities Report is to identify differences in quality of and access to care between populations and to track how these gaps are changing over time. This report measures trends in effectiveness of care, patient safety, timeliness of care, patient centeredness, and efficiency of care. The report presents expanded analyses on long-term trends in performance, regional and State differences in quality, and health care disparities for granular ethnicity categories. It also addresses six priority areas for quality improvement, as identified in the National Strategy for Quality Improvement in Health Care and presents novel strategies for improving quality and reducing disparities from AHRQ’s Health Care Innovations Exchange.

2. 2012 National Healthcare Quality Report
   http://nhqrnet.ahrq.gov/inhqrdr/reports/nhqr

   This report is featured on the Agency for Healthcare Research and Quality’s Web site. The key function of the National Healthcare Quality Report is to summarize the state of health care quality and access for the Nation, and report on progress and opportunities for improving health care quality. This report measures trends in effectiveness of care, patient safety, timeliness of care, patient centeredness, and efficiency of care. The 2012 report presents expanded analyses of care received by older Americans. It also addresses six priority areas for quality improvement, as identified in the National Strategy for Quality Improvement in Health Care, and presents novel strategies for improving quality and reducing disparities from AHRQ’s Health Care Innovations Exchange.

3. 2014 Long Term Care National Patient Safety Goals
   http://www.jointcommission.org/standards_information/npsgs.aspx

   The purpose of the Joint Commission Long Term Care National Patient Safety Goals is to improve patient safety in a long-term care setting by focusing on specific goals. This Web site contains a link to the latest goals, which include improvements emanating from the Standards Improvement Initiative. In addition, the site has information on the new numbering system and minor language changes for consistency.

4. 30 Safe Practices for Better Health Care Fact Sheet

   This fact sheet is featured on the Agency for Healthcare Research and Quality’s Health Care Innovations Exchange. The National Quality Forum has identified 30 safe practices that, evidence shows, can work to reduce or prevent adverse events and medication errors. These practices can be universally adopted by all health care settings to reduce the risk of harm to patients. This tool also provides background information about the National Quality Forum, as well, as links to a report providing more detailed information about the 30 Safe Practices.
5. **ADOPT Toolkit**
http://toolkit.techandaging.org/

This tool was developed by the Center for Technology and Aging; Public Health Institute and is featured on the AHRQ Health Care Innovations Exchange Web site. This Web site, for health care providers, offers “how to” resources on using technology to assist care coordination and improve the independence of older adults. The guides range from planning and development to implementation and evaluation in the following four areas:

- Remote patient monitoring.
- Medication optimization.
- Care transitions.
- Mobile health.

The toolkits contain checklists, lessons learned, and other resources to help to simplify the complex steps to successfully adopt a new technology.

6. **Advance Care Planning: Preferences for Care at the End of Life**

This report is featured on the Agency for Healthcare Research and Quality’s Web site. The report presents findings from research funded by AHRQ and can help health care professionals offer end-of-life care based on preferences most patients have in similar circumstances.

7. **Advancing Excellence in America’s Nursing Homes**
http://www.nhqualitycampaign.org/star_index.aspx?controls=welcome

Advancing Excellence in America’s Nursing Homes is an ongoing coalition-based campaign concerned with how we care for older adults, chronically ill and disabled people, and people recuperating in a nursing home environment. This voluntary campaign monitors key indicators of nursing home care quality, both clinical quality and organizational improvement goals; promotes excellence in caregiving; acknowledges the critical role nursing home staff have in providing care; and recognizes the important role of consumers in contributing ideas and suggestions to the campaign.

8. **AHRQ Health Care Innovations Exchange**
http://www.innovations.ahrq.gov/

The Agency for Healthcare Research and Quality’s Health Care Innovations Exchange is a comprehensive program designed to accelerate the development and adoption of innovations in health care delivery. This program supports AHRQ’s mission to improve the safety, effectiveness, patient centeredness, timeliness, efficiency, and equity of care, with a particular emphasis on reducing disparities in health care and health among racial, ethnic, and socioeconomic groups.
The Innovations Exchange has the following components:

- Searchable innovations and attempts
- Searchable QualityTools
- Learning opportunities
- Networking opportunities

9. AHRQ Patient Safety Network  
http://psnet.ahrq.gov/

The Patient Safety Network (PSNet) is a national Web-based resource featuring the latest news and essential resources on patient safety. The site offers weekly updates of patient safety literature, news, tools, and meetings (What’s New), and a vast set of carefully annotated links to important research and other information on patient safety (The Collection). Supported by a robust patient safety taxonomy and Web architecture, AHRQ PSNet provides powerful searching and browsing capability, as well as the ability for diverse users to customize the site around their interests (My PSNet). It also is tightly coupled with AHRQ WebM&M, the popular monthly journal that features user-submitted cases of medical errors, expert commentaries, and perspectives on patient safety.

10. AHRQ Quality and Patient Safety  
http://www.ahrq.gov/qual/errorsix.htm

The Agency for Healthcare Research and Quality’s Quality and Patient Safety Web page provides links to various resources and tools for promoting patient safety in various categories, including:

- Comprehensive Unit-based Safety Program (CUSP)
- Patient Safety Measure Tools & Resources
- Pharmacy Health Literacy Center
- Surveys on Patient Safety Culture
- Quality Measure Tools & Resources

11. Always Events® Toolbox  
http://alwaysevents pickerinstitute.org/?page_id=882

This tool was developed by the Picker Institute and is featured on the AHRQ Health Care Innovations Exchange Web site. The toolbox contains tools and strategies to assist health care professionals in implementing Always Events® initiatives and meeting their patient- and family-centered care goals. Always Events are defined as “those aspects of the patient and family experience that should always occur when patients interact with healthcare professionals and the delivery system.” These tools and strategies were developed by numerous health care professionals from across the country as they implemented initiatives designed to enhance the care provided to patients through the implementation of Always Events.

This tool was developed by the American Academy of Neurology and is featured on the AHRQ Health Care Innovations Exchange Web site. The tool provides guidelines that summarize the best research on recognizing, diagnosing, and providing treatment options for people with Alzheimer’s disease and their families. It addresses the following topics:

- How can you recognize Alzheimer’s disease?
- How does a doctor diagnose Alzheimer’s disease?
- What are the treatment and care options available today?
- Where can you find more resources?
- The 10 warning signs of Alzheimer’s disease


This tool was developed by the American Academy of Neurology and is featured on the AHRQ Health Care Innovations Exchange Web site. The tool is a two-page summary of three AAN guidelines on dementia. This summary focuses on Alzheimer’s disease, for which current evidence is strongest and clearest, and addresses the following practice parameters:

- Detection of dementia – Mild cognitive impairment.
- Diagnosis of dementia.
- Management of dementia.

This summary also presents strategies to improve functional performance and reduce problem behaviors in patients with Alzheimer’s disease.

14. CAHPS® Improvement Guide

The extensive and growing use of CAHPS® (Consumer Assessment of Healthcare Providers and Systems) surveys to assess the quality of health plans, medical groups, and other organizations has created a demand for practical strategies that organizations can use to improve patients’ experiences with care. This guide is designed to help meet this need. It is aimed at executives, managers, physicians, and other staff responsible for measuring performance and improving the quality of services provided by health plans, medical groups, and individual physicians. Over time, this guide will be updated to include new improvement interventions and offer additional resources.
15. CAHPS® Nursing Home Surveys


The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) program is a multiyear AHRQ initiative. This Web site provides information on the CAHPS Nursing Home Surveys, as well as links to three separate instruments: an in-person questionnaire for long-term residents, a mail questionnaire for recently discharged short-stay residents, and a questionnaire for residents’ family members.


This page provides basic information about being certified as a Medicare or Medicaid nursing home provider and includes links to applicable laws, regulations, and compliance information. The site also has related nursing home reports, compendia, and a list of special focus facilities (i.e., nursing homes with a record of poor survey [inspection] performance on which CMS focuses extra attention) available for download.

17. Chasing Zero: Winning the War on Healthcare Harm

http://www.safetyleaders.org/pages/chasingZeroDocumentary.jsp

A near-fatal medical error almost cost the lives of twins born to actor Dennis Quaid and his wife. This real-life event inspires a new patient education documentary featuring the Quaid family’s personal ordeal, along with stories of other families who faced medical errors. It also features experts who are leading efforts to help health care providers reduce medical errors and improve patient safety outcomes.

18. Coordinated-Transitional Care Toolkit

http://www.hipxchange.org/C-trac

This tool was developed by the University of Wisconsin-Madison School of Medicine & Public Health and the William S. Middleton Memorial Veterans Hospital, and is featured on the AHRQ Health Care Innovations Exchange Web site. The Coordinated-Transitional Care (C-TraC) Toolkit is a low-resource, telephone-based, protocol-driven program designed to reduce 30-day rehospitalizations and to improve care transitions during the early posthospital period. The goal of this toolkit is to help hospital systems that serve populations with high rates of patient dispersion, cognitive impairment, and vulnerability improve care coordination and postdischarge outcomes such as reduced medication discrepancies. The toolkit is designed to help clinicians and researchers execute the C-TraC program protocol.

Highlights of the C-TraC program toolkit include the following:

- An overview of barriers to providing high-quality transitional care.
- Core components of the C-TraC program protocol.
• A step-by-step guide to executing the C-TraC program protocol.
• An overview of common challenges to managing the C-TraC program protocol.

19. Commission on Accreditation of Rehabilitation Facilities
http://www.carf.org/home/

The CARF International family of organizations, including CARF, CARF Canada, and CARF-CCAC, is an independent, nonprofit accreditor of health and human service providers. Through accreditation, CARF assists service providers in improving the quality of their services, demonstrating value, and meeting internationally recognized organizational and program standards.

20. The Commonwealth Fund
http://www.commonwealthfund.org/

The Commonwealth Fund is a private foundation that aims to promote a high-performing health care system that achieves better access, improved quality, and greater efficiency. Efforts are aimed particularly at society's most vulnerable populations, including low-income people, uninsured people, racial and ethnic minority groups, young children, and older adults. The Commonwealth Fund provides information on a variety of health care topics, free publications, and innovations and tools for improving health care.

21. Consumers Advancing Patient Safety
http://www.patientsafety.org/

Consumers Advancing Patient Safety (CAPS) is a consumer-led nonprofit organization aimed at providing a collective voice for individuals, families, and healers who want to prevent harm in health care encounters through partnership and collaboration.

22. Delirium Facility Assessment Checklists

This 11-page quality tool is featured on the AHRQ Health Care Innovations Exchange Web site. It provides self-assessment checklists for nursing home staff to use in assessing processes related to delirium in the facility, in order to identify areas that need improvement. This tool includes checklists on the following delirium-related topics: delirium assessment, delirium care plans, delirium screening, and staff education and training.

23. Dementia Capability Toolkit

This toolkit was developed by the Alzheimer’s Association and is featured on the AHRQ Health Care Innovations Exchange Web site. The Dementia Capability Toolkit identifies resources that States and communities can use to design initiatives to ensure that programs are dementia capable. In dementia-capable systems, programs are tailored to the unique needs of people with Alzheimer’s disease or other dementias and their caregivers.
24. Department of Defense Patient Safety Program  

The Department of Defense Patient Safety Program is a comprehensive program designed to establish a culture of patient safety and quality within the Military Health System (MHS). The program encourages a systems approach to create a safer patient environment; engages MHS leadership; promotes collaboration across all three Services; and fosters trust, transparency, teamwork, and communication.

25. Development of the Artifacts of Culture Change Tool  
http://paculturechangecoalition.org/Resources/Articles/Cms%20-%20Culture%20Change%20Artifact%20Tool%20Explanation.Pdf

This tool was developed by the Centers for Medicare & Medicaid Services and Edu-Catering and is featured on the AHRQ Health Care Innovations Exchange Web site. The Artifacts of Culture Change Tool is a nursing home self-evaluation questionnaire containing 79 items to evaluate progress in changing culture to improve care processes in areas such as:

- Care practice.
- Environment.
- Family and community.
- Leadership.
- Workplace practices.
- Outcomes.

26. Enhanced Toileting Program Reduces Incontinence and Its Comorbidities Among Residents of Long-Term Care Facility  
http://www.innovations.ahrq.gov/content.aspx?id=2245

This featured profile is available on the AHRQ Health Care Innovations Exchange Web site. A long-term care facility adopted an enhanced toileting program consisting of the following components: individualized toileting plan of care based on periodic resident assessments, revised and new care documentation tools, devices to assist with toileting, and comprehensive education and training for facility staff. The program led to a sharp decline in the prevalence of incontinence (from 76 to 38 percent of residents) and in associated comorbidities and staff injuries.

27. Get Connected! Toolkit: Linking Older Adults With Medication, Alcohol, and Mental Health Resources  
http://www.samhsa.gov/Aging/docs/GetConnectedToolkit.pdf

This toolkit was developed by the National Council on Aging and is featured on the AHRQ Health Care Innovations Exchange Web site. The Get Connected! Toolkit was created to help service providers for older adults learn more about alcohol and medication misuse and mental health problems in older adults to address these issues more effectively. It has been designed to help these service providers undertake health promotion, advance prevention messages and education, and undertake screening and referral for mental health problems and misuse of
alcohol and medications. This toolkit helps providers coordinate these efforts and links organizations and the older adults they serve to other valuable community-based and national resources.

28. Home-Like, Self-Directed Environment Provides Superior Quality of Life Than in Traditional Nursing Homes and Assisted Living Facilities


This featured profile is available on the AHRQ Health Care Innovations Exchange Web site. THE GREEN HOUSE® model provides older adults with an alternative to nursing homes and traditional assisted living facilities. These communities provide groups of 7 to 10 older adults a comfortable, warm, home environment and staff who provide the highest level of clinical care while nurturing relationships and older adults’ autonomy. A 30-month evaluation suggests that THE GREEN HOUSE® adults receive equal or higher quality of care and report better quality of life than residents of nursing homes.

29. Immunizations Toolkit


This toolkit is featured on the AHRQ Health Care Innovations Exchange Web site. It was developed to increase immunization rates among nursing home residents and staff. It offers specific information and education on the benefits of influenza (flu) and pneumonia immunization, as well as sample guidelines and tools needed to run an effective and sustainable resident and staff immunization program.

30. Improvement Capability Self-Assessment Tool

http://www.ihi.org/resources/Pages/Tools/IHIImprovementCapabilitySelfAssessmentTool.aspx

The IHI Improvement Capability Self-Assessment Tool is designed to assist organizations in assessing their capability in six key areas that support improvement:

- Leadership for Improvement
- Results
- Resources
- Workforce and Human Resources
- Data Infrastructure and Management
- Improvement Knowledge and Competence

31. Institute for Healthcare Improvement

http://www.ihi.org/ihi

The Institute for Healthcare Improvement is a reliable source of energy, knowledge, and support for a never-ending campaign to improve health care worldwide. The institute helps accelerate change in health care by cultivating promising concepts for improving patient care and turning those ideas into action.
32. Institute for Safe Medication Practices  
http://www.ismp.org

The Institute for Safe Medication Practices offers a wide variety of free educational materials and services on their Web site:

- Special Medication Hazard Alerts
- Searchable information on a wide variety of medication safety topics
- Answers to Frequently Asked Questions about medication safety
- Food and Drug Administration Patient Safety Videos
- Pathways for Medication Safety Tools
- White papers on bar-coding technology and electronic prescribing
- A monitored Message Board to share questions, answers, and ideas

33. ISHAPED Patient-Centered Approach to Nurse Shift Change Bedside Report  

The “ISHAPED” (I=Introduce, S=Story, H=History, A=Assessment, P=Plan, E=Error Prevention, and D=Dialogue) project focuses on making bedside shift reports more patient and family centered. The goal is to always include patients in the ISHAPED nursing shift-to-shift handoff process at the bedside to add another layer of safety by enabling the patient to communicate potential safety concerns.

34. The Joint Commission: Patient Safety  
http://www.jointcommission.org/topics/patient_safety.aspx

The Patient Safety pages on the Joint Commission Web site offer information on patient safety-related standards, the National Patient Safety Goals, the Speak Up™ initiatives (a national program urging patients to become active participants on their health care team), and other resources.

35. LeadingAge  
http://www.leadingage.org/

LeadingAge is a community of not-for-profit organizations in the United States who have come together to focus on advocacy, education, and applied research to support long-term care. LeadingAge promotes adult day services, home health, hospice, community-based services, Programs of All-inclusive Care for the Elderly, senior housing, assisted living residences, continuing care communities, and nursing homes, as well as technology solutions and person-centered practices that support the overall health and well-being of seniors, children, and people with special needs.
36. Long-Term Care Improvement Guide
http://www.residentcenteredcare.org/LTC%20Improvement%20Guide%20For%20Download.pdf

This guide was developed by Planetree, Inc., to propel long-term care communities in their improvement efforts by presenting a collection of concrete strategies for actualizing a resident-directed, relationship-centered philosophy. It supplies providers with tools, data, and practical resources so they can make informed decisions as they consider implementing culture change initiatives to deliver person-centered care.

37. Making Your Printed Health Materials Senior Friendly

This tip sheet was developed by the National Institute on Aging and is featured on the AHRQ Health Care Innovations Exchange Web site. This tip sheet describes how to tailor health information when writing for older adults and when designing materials for older adults.

38. Multimorbidity Pocket Card

This tool is based on Patient-Centered Care for Older Adults with Multiple Chronic Conditions: A Stepwise Approach from the American Geriatrics Society and has been developed to assist health care providers implement the 5 Guiding Principles in taking care of older adults with multimorbidity.

39. National Blueprint: Increasing Physical Activity Among Adults Age 50 and Older
http://www.physicalactivityplan.org/resources/BlueprintPA-OlderAdults.pdf

This tool was developed by the Robert Wood Johnson Foundation and is featured on the AHRQ Health Care Innovations Exchange Web site. The tool was developed to guide organizations, associations, and agencies in planning strategies to help people age 50 and older increase their physical activity.

40. National Center for Patient Safety
http://www.patientsafety.gov

The National Center for Patient Safety (NCPS) was established in 1999 to develop and nurture a culture of safety throughout the Department of Veterans Affairs. The primary intended audience for the public Web site is health care professionals and health care administrators.

41. National Institute on Aging: Health & Aging
http://www.nia.nih.gov/health

The National Institute on Aging provides leadership in research on aging, training, health information dissemination, and other programs relevant to aging and older people.
This Web site includes the following:

- Publications: Information and tips on healthy aging, caregiving, medications, dietary supplements, and diseases.
- Clinical trials: Federally and privately supported clinical research with human volunteers.
- Related sites: A list of National Institutes of Health and other Federal agency Web sites of interest to people working with older adults.
- Health and aging organizations: This online, searchable database lists more than 300 national organizations that provide help to older people.

42. National Patient Safety Foundation®
http://www.npsf.org/

The National Patient Safety Foundation® (NPSF) has been pursuing one mission since its founding in 1997 – to improve the safety of the health care system for the patients and families it serves. NPSF is unwavering in its determined and committed focus on uniting disciplines and organizations across the continuum of care, championing a collaborative, inclusive, multi-stakeholder approach.

43. National Quality Forum
http://www.qualityforum.org/Topics/Safety_pages/Patient_Safety.aspx

The National Quality Forum (NQF) is a nonprofit organization that aims to improve the quality of health care for all Americans through fulfillment of its three-part mission:

- Setting national priorities and goals for performance improvement;
- Endorsing national consensus standards for measuring and publicly reporting on performance; and
- Promoting the attainment of national goals through education and outreach programs.

44. National Quality Strategy Stakeholder Toolkit
http://www.ahrq.gov/workingforquality/nqs/nqstoolkit.pdf

This toolkit is featured on the AHRQ Health Care Innovations Exchange Web site. The toolkit was created to support the activities of private and public organizations to advance the mission of the NQS. This toolkit contains fact sheets that can be printed and distributed, blogs and social media announcements for online use, and briefing slides for presentations that can be used to explain the national effort to improve the health and health care of all Americans. The information can be tailored to suit an organization’s messaging about its involvement in the National Quality Strategy, which sets priorities to achieve better care, healthy people/healthy communities, and more affordable care.
45. Nursing Home “Neighborhoods” Emphasize Dignity and Independence, Leading to Improvements in Resident Health and Quality of Life and Lower Employee Turnover

This featured profile is available on the AHRQ Health Care Innovations Exchange Web site. Providence Mount St. Vincent (known as “The Mount”) developed and implemented a new model for nursing home care in which most residents live in a – neighborhood of 20 to 23 residents containing a cluster of private and semiprivate rooms and a large kitchen/dining area that serves as the central gathering spot for meals and activities. The Mount’s approach also focuses on giving residents more independence, autonomy, and dignity than in a traditional nursing home, leading to a greater sense of community and a higher quality of life for residents, as well as a better work environment for employees.

46. Nursing Home Quality Initiative

The Nursing Home Quality Initiative (NHQI) Web site provides consumer and provider information regarding the quality of care in nursing homes. NHQI discusses quality measures that are shown at the Nursing Home Compare Web site (medicare.gov), which allows consumers, providers, States, and researchers to compare information on nursing homes. Many nursing homes have already made significant improvements in the care being provided to residents by taking advantage of these materials and the support of Quality Improvement Organization staff.

47. Older Adults: Designing Health Information To Meet Their Needs
http://www.cdc.gov/healthliteracy/developmaterials/audiences/olderadults/index.html

This Web site provides tools and resources to help public health professionals improve their communication with older adults by focusing on health literacy issues. These resources are for all professionals and organizations that interact and communicate with older adults about health issues. These organizations include public health departments, health care providers and facilities, government agencies, nonprofit/community advocacy organizations, the media, and health-related industries.

48. On-Time Quality Improvement Manual for Long-Term Care Facilities

The On-Time Quality Improvement program is a practical approach to quality improvement (QI) in long-term care, embedding QI strategies and best practices into health information technology. This manual is an introduction to the On-Time QI approach. It provides an overview of the tools and process improvements and describes the implementation process. Target users are stakeholders interested in nursing home QI, nursing home leaders responsible for deciding QI priorities, and nursing home personnel responsible for QI.
49. Patient-Centered Care Improvement Guide
http://www.ihi.org/resources/Pages/Tools/PatientCenteredCareImprovementGuide.aspx

This guide was developed by Planetree (in collaboration with Picker Institute). The guide is designed as a practical resource for health care organizations that are striving to become more patient centered. It contains best practices and practical implementation tools contributed by hospitals from across the United States. The Self-Assessment Tool can help identify and prioritize opportunities for introducing patient-centered approaches into your organization.

50. Patient Safety Primer: Medication Errors

A growing evidence base supports specific strategies to prevent adverse drug events (ADEs). The AHRQ Patient Safety Network outlines strategies providers can use at each stage of the medication use pathway – prescribing, transcribing, dispensing, and administration – to prevent ADEs. These strategies range from computerized provider order entry and clinical decision support to minimizing nurse disruption and providing better patient education and medication labeling. The primer also identifies known risk factors for ADEs, including health literacy, patient characteristics, high-alert medications, and transitions in care.

51. Pennsylvania Patient Safety Authority
http://www.patientsafetyauthority.org/Pages/Default.aspx

The Pennsylvania Patient Safety Authority is charged with taking steps to reduce and eliminate medical errors by identifying problems and recommending solutions that promote patient safety in various health care settings. The Web site features current patient safety articles and highlights patient safety initiatives and tools. Users can browse by care setting, event (e.g., falls, medication errors), discipline, audience, and patient safety focus.

52. Person-Directed Care Toolkit
http://www.innovations.ahrq.gov/content.aspx?id=2649

This tool is featured on the AHRQ Innovations Exchange Web site. TMF Health Quality Institute developed this toolkit to help nursing home staff move from an institutional care model to a more individualized care model. It includes educational materials, change ideas, and much more to facilitate this culture change journey.

53. Pioneer Network
https://www.pioneernetwork.net

Pioneer Network is a center for all stakeholders in the field of aging and long-term care whose focus is on providing home and community for elders. The Pioneer Network believes that the quality of life and living for America’s elders is rooted in a supportive community and cemented by relationships that respect each of us as individuals regardless of age, medical condition, or limitations. The Web site features webinar series on hot topics in long-term care, stories from the field, and other resources.
54. Quality Improvement Savings Tracker Worksheet
http://www.ihi.org/resources/Pages/Tools/QISavingsTrackerWorksheet.aspx

The Quality Improvement Savings Tracker Worksheet may be used throughout the organization to track cost savings associated with waste reduction efforts and to adjust for annual changes. The tool enables the organization to compare expenses in the area of interest to expenses incurred the year prior and adjust for wage increases and productivity/volume changes. The organization can then use the worksheet to track any investments made with the savings accrued.

55. SAFER Guides
http://www.healthit.gov/policy-researchers-implementers/safer

SAFER guides, released by the Office of the National Coordinator for Health Information Technology (ONC) at the Department of Health and Human Services, are a suite of tools designed to help health care providers and the organizations that support them assess and optimize the safety and safe use of electronic health information technology products, such as electronic health records (EHRs). Each SAFER Guide addresses a critical area associated with the safe use of EHRs through a series of self-assessment checklists, practice worksheets, and recommended practices. Each SAFER Guide has extensive references and is available as a downloadable PDF and as an interactive web-based tool.

Areas addressed include:

- High Priority Practices
- Organizational Responsibilities
- Patient Identification
- Computerized Physician Order Entry (CPOE) with Decision Support
- Test Results Review and Follow-up
- Clinician Communication
- Contingency Planning
- System Interfaces
- System Configuration

56. Staying Healthy Through Education and Prevention (STEP)

This tool was developed by Good Samaritan Society and Leading Edge. The Staying Healthy Through Education and Prevention (STEP) implementation guide is a tool for continuing care retirement community staff to implement the STEP program. The STEP program is an evidence-based exercise program focusing on walking and strength training for seniors. This guide provides the information, tools, curricular material, and other resources needed to successfully implement the STEP program in continuing care retirement communities.
57. WHO Collaborating Centre for Patient Safety Solutions


58. Why Not the Best?
http://whynotthebest.org/contents/

Why Not the Best is a health care quality improvement resource from the Commonwealth Fund. In this resource, health care organizations share successful strategies and tools to create safe, reliable health care processes and deliver high-quality care to patients. Case studies and tools are linked to performance measures for particular conditions or areas of care.

Falls Management/Prevention

1. Best Practice Intervention Packages for Fall Prevention
http://www.homehealthquality.org/Education/Best-Practices.aspx

The Best Practice Intervention Packages (BPIP) were designed for use by any home health agency to support efforts to reduce avoidable acute care hospitalizations. The topic of this package is falls prevention.

2. Department of Veteran Affairs National Center for Patient Safety Falls Toolkit
http://www.patientsafety.va.gov/professionals/onthejob/falls.asp

The Department of Veterans Affairs National Center for Patient Safety (NCPS) worked with the Patient Safety Center of Inquiry in Tampa, Florida, and others to develop the NCPS Falls Toolkit. The toolkit is designed to aid facilities in developing a comprehensive falls prevention program. This Web site contains links to the falls notebook, media tools, and additional resources.

3. Falls Free: Promoting a National Falls Prevention Action Plan

This tool was developed by the Archstone Foundation, the Home Safety Council, and the National Council on Aging and is featured on the AHRQ Health Care Innovations Exchange Web site. This action plan was developed in response to escalating concerns about falls and fall-related injuries among the aging population. It highlights strategies and preliminary action steps developed by participants in the Falls Free Summit. Thirty-six strategies are proposed, based on input from summit participants, organized under five goal areas.
4. **Falls in Nursing Homes Fact Sheet**  

This fact sheet identifies the problem of falls in nursing homes and offers strategies for preventing falls.

5. **Falls Management Program**  

This interdisciplinary program is available from AHRQ. It is designed to assist nursing facilities in improving their fall care processes and outcomes through educational and quality improvement tools.

6. **Interdisciplinary Team Identifies and Addresses Risk Factors for Falls Among Nursing Home Residents, Leading to Fewer Falls and Less Use of Restraints**  
http://www.innovations.ahrq.gov/content.aspx?id=1835

This featured profile is available on the AHRQ Innovations Exchange Web site. Ethica Health and Retirement Communities has developed a falls management program, the cornerstone of which is an interdisciplinary - falls team at each nursing home that regularly assesses residents for their risk of falling and develops intervention plans for those found to be at high risk. The team also documents and investigates every fall and takes steps to reduce the chance of recurrence. The program led to a slight decline in falls and a large reduction in use of restraints.

7. **Limiting Physical Restraint Use**  
http://primaris.org/limiting-physical-restraint-use

Primaris and a group of Missouri nursing homes collaborated on a 3-year project to reduce the use of physical restraints. This Web site provides background information on restraints and free quality improvement resources on this topic, including a variety of checklists and educational materials.

8. **Patient Fall Prevention and Management Protocol With Toileting Program**  
http://www.ihi.org/resources/Pages/Tools/PatientFallPreventionManagementProtocolwithToileti ngProgramVAMCBayPines.aspx

This tool is used to identify patients at risk for falls and to outline recommendations for the nursing management of patients at risk for falls or who have a history of falls.

9. **Primary Care Provider Fax Report and Orders**  

This tool is used to communicate the results of a falls assessment to the physician, nurse practitioner, or physician’s assistant. It includes a FAX Cover Sheet, Falls Assessment Report, and Fax Back Orders for the primary care provider to complete.
10. Restraint Toolkit


This tool is featured on the AHRQ Health Care Innovations Exchange Web site. TMF Health Quality Institute developed this toolkit to help nursing home staff limit the use of physical restraints. Some of the resources included are:

- Restraint-free days tool.
- Side rail utilization assessment.
- Fall prevention: Avoid these drugs in the elderly.
- Restraint evaluation worksheet/data collection tool.
- Progress toward restraint reduction worksheet and instructions.
- Quality improvement workbook.
- Making the right choice (also available in Spanish).

Pressure Ulcer Reduction

1. Braden Scale for Predicting Pressure Sore Risk

   This rating scale for nurses and other health care providers is featured on the AHRQ Health Care Innovations Exchange Web site. It predicts a patient’s level of risk for developing pressure ulcers. The scale is composed of six subscales that measure functional capabilities of the patient that contribute to either higher intensity and duration of pressure or lower tissue tolerance for pressure.

2. Daily Skin Care Flow Sheet
   http://www.ihi.org/resources/Pages/Tools/DailySkinCareFlowSheet.aspx

   This tool was developed by the Yuma Regional Medical Center and is used by nurses to help identify the interventions needed for those patients with an identified deficit in any or all of the Braden subscales.

3. How-To Guide: Prevent Pressure Ulcers
   http://www.ihi.org/resources/Pages/Tools/HowtoGuidePreventPressureUlcers.aspx

   This guide was developed by the Institute for Healthcare Improvement and describes key evidence-based care components for preventing pressure ulcers, describes how to implement these interventions, and recommends measures to gauge improvement. The guide was initially developed as part of IHI’s 5 Million Lives Campaign.
4. **Indiana Pressure Ulcer Quality Improvement Initiative: Forms & Handouts**

The Indiana Pressure Ulcer Quality Improvement Initiative provides education, training, and technical assistance to reduce the incidence of pressure ulcers in nursing homes and in other health care sites throughout the State of Indiana.

5. **On-Time Quality Improvement for Program**

AHRQ launched a program to help frontline nursing home staff reduce the occurrence of in-house pressure ulcers, providing residents with more efficient, effective, and patient-centered care. The On-Time Quality Improvement for Long-Term Care program is an innovative program designed to improve day-to-day practice in nursing homes, improve and redesign workflow, enrich work culture, and reduce pressure ulcers. This Web site contains program materials, a video, and readiness and health information technology assessment tools available for download.

6. **Pressure Ulcer Clinical Tools & Resources**

This tool is featured on the AHRQ Health Care Innovations Exchange Web site. Information & Quality Healthcare works with nursing homes to reduce the number of patients with pressure ulcers. This site provides various resources on the assessment, treatment, and prevention of pressure ulcers. The tools available for download include:

- Pressure ulcer data tracking resources.
- Other pressure ulcer resources.
- Quick assessment of leg ulcers.
- Skin check form.
- Communication form.
- Skin care plan form.

7. **Pressure Ulcer Prevention Points**
   [http://www.ihi.org/resources/Pages/Tools/PressureUlcerPreventionPoints.aspx](http://www.ihi.org/resources/Pages/Tools/PressureUlcerPreventionPoints.aspx)

This tool was developed by the National Pressure Ulcer Advisory Panel. This tool provides a detailed description of pressure ulcer prevention points, with references to literature and other resources.
8. Pressure Ulcer Reduction Toolkit
http://nursinghomes.tmf.org/PressureUlcers/PressureUlcerToolkit/tabid/545/ctl/Login/Default.aspx?returnurl=%2fPressureUlcers%2fPressureUlcerToolkit%2ftabid%2f545%2fDefault.aspx (requires login)

This tool is featured on the AHRQ Health Care Innovations Exchange Web site. TMF Health Quality Institute developed this toolkit to help nursing home staff better prevent and treat pressure ulcers. The toolkit includes:

- Facility-acquired pressure ulcer investigation tool.
- Protein-energy malnutrition definition.
- Team progress assessment.
- Facility-acquired pressure ulcer-free days calendar tool.
- Facility-level assessment.
- Resident-level assessment.
- Quality improvement workbook.
- Facility assessment checklist.
- Organizational commitment.
- Risk assessment.
- Development of a plan of care.

9. Pressure Ulcer Prevention: A Nursing Competency-Based Curriculum
http://www.ihi.org/resources/Pages/Tools/PressureUlcerPreventionAnNursingCompetencybasedCurriculum.aspx

This training was developed by the National Pressure Ulcer Advisory Panel, which provides this sample curriculum to prepare registered nurses with the minimum competencies for pressure ulcer prevention.

10. Prevention and Treatment Program Integrates Actionable Reports Into Practice, Significantly Reducing Pressure Ulcers in Nursing Home Residents
http://www.innovations.ahrq.gov/content.aspx?id=2153

This featured profile is available on the AHRQ Health Care Innovations Exchange Web site. The On-Time Pressure Ulcer Prevention and Treatment Program uses standardized documentation data elements and actionable clinical reports that are integrated into practice at nursing homes; the goal of the program is to help nursing home staff identify and address risk factors for pressure ulcers in residents.

11. Preventing Pressure Ulcers Turn Clock Tool
http://www.ihi.org/resources/Pages/Tools/PreventingPressureUlcersTurnClockTool.aspx

The turn clock tool is posted to alert staff that this patient has been identified as being at risk for pressure ulcers. It serves as an important reminder to reposition the patient every 2 hours, a key component of care for at-risk patients.
12. Skin Care Facts: Pressure Ulcer Prevention
http://www.ihi.org/resources/Pages/Tools/SkinCareFactsPressureUlcerPrevention.aspx

This fact sheet was developed by Iowa Health in Des Moines. This poster can be used to display important facts about skin care necessary to avoid pressure ulcers.

13. Staff Training and Support, Incentives, and Feedback Fails To Generate Sustainable Reductions in Pressure Ulcers at Nursing Home
http://www.innovations.ahrq.gov/content.aspx?id=1895

This profile is available on the AHRQ Health Care Innovations Exchange Web site. Guided by a university research team, a 136-bed, not-for-profit nursing home in Pennsylvania implemented a quality improvement program to reduce the incidence of pressure ulcers (PUs). The program had three components: increasing workers’ ability to recognize and prevent PUs, giving them incentives to perform better, and providing management and staff with performance feedback. Although there was a significant reduction in PUs during the program’s 3-month implementation period, these gains were not sustained.

14. Pressure Ulcer Baseline Assessment Survey for Registered Nurses and Nursing Assistants
http://www.ihi.org/resources/Pages/Tools/PressureUlcerBaselineAssessmentSurveyforRegisteredNursesandNursingAssistants.aspx

This self-assessment tool can be used by nurses to determine their knowledge of how to prevent and care for pressure ulcers.

Pain Management

1. Enhancing the Management of Neuropathic Pain in the Long-Term Care Setting
http://achlpicme.org/ltc/CMEInfo.aspx

This tool was developed by the Academy for Continued Healthcare Learning (ACHL) and is featured on the AHRQ Health Care Innovations Exchange Web site. The toolkit provides strategies and templates to help long-term care facilities and their clinicians implement a performance improvement project. The goal of this project is to help clinicians accurately and appropriately manage residents with neuropathic or persistent pain.

Resources by Dimension

The following resources are organized according to the relevant Nursing Home Survey on Patient Safety Culture dimensions they can help improve. Some resources are duplicated and cross-referenced because they may apply to more than one dimension.
Dimension 1. Overall Perceptions of Resident Safety


This resource guide is featured on the AHRQ Health Care Innovations Exchange Web site. It provides tools to assist health care facilities in implementing a patient safety program. This toolkit includes the following program tools, all of which may be customized as needed:

- Generic safety plan: template
- Comprehensive medical safety program
- Quality and safety officer job description: template
- Organized assignments for accompanying patient safety plan or program
- American Society for Healthcare Risk Management: Perspective on disclosure of unanticipated outcome information
- Checklist for patient safety and Joint Commission on the Accreditation of Healthcare Organizations standards

2. Improving Resident Safety in Long-Term Care Facilities

This article identifies tips for improving resident safety, including general information and specific tips on falls and wanderers.

http://www.ahrq.gov/research/findings/evidence-based-reports/ptsafetyuptp.html

This evidence report is featured on the AHRQ Health Care Innovations Exchange Web site. It presents practices relevant to improving patient safety, focusing on hospital care, nursing homes, ambulatory care, and patient self-management. It defines patient safety practices, provides a critical appraisal of the evidence, rates the practices, and identifies opportunities for future research.

4. Patient Safety Self-Assessment Tool
http://www.ihi.org/resources/Pages/Tools/PatientSafetySelfAssessmentTool.aspx

This organizational self-assessment tool was designed by Steven Meisel, PharmD, at Fairview Health Services using information from a report published by the Agency for Healthcare Research and Quality (AHRQ) in Rockville, Maryland, USA. The tool can help staff members evaluate whether known safety practices are in place in their organizations and to find areas for improvement.
5. **Patient Safety Primer: Safety Culture**  

The concept of safety culture originated outside health care, in studies of high-reliability organizations. These organizations consistently minimize adverse events despite carrying out intrinsically complex and hazardous work. High-reliability organizations maintain a commitment to safety at all levels, from frontline providers to managers and executives. This commitment establishes a culture of safety. The AHRQ Patient Safety Network explains this topic further and provides links for more information on what is new in safety culture.

6. **Studer Group Toolkit: Patient Safety**  

This toolkit is featured on the AHRQ Health Care Innovations Exchange Web site. It provides health care leaders and frontline staff specific tactics they can immediately put into action to improve patient safety outcomes. By routinizing specific behaviors, organizations can improve patient safety without purchasing new equipment, adding staff, or spending additional time to put them into practice. The actions are divided into eight sections, each of which has been identified as a priority area for health care organizations to address as they seek to provide safer care.

7. **Trigger Tool for Measuring Adverse Drug Events in the Nursing Home**  

The Trigger Tool for Measuring Adverse Drug Events in the Nursing Home includes a list of triggers that can be used by clinicians to detect ADEs specifically for use in the nursing home setting.

**Dimension 2. Feedback and Communication About Incidents**

1. **Conduct Safety Briefings**  
[http://www.ihi.org/resources/Pages/Changes/ConductSafetyBriefings.aspx](http://www.ihi.org/resources/Pages/Changes/ConductSafetyBriefings.aspx)

Safety briefings in patient care units are tools to increase safety awareness among frontline staff and foster a culture of safety. This Institute for Healthcare Improvement Web site identifies tips and tools for conducting safety briefings.

2. **Provide Feedback to Frontline Staff**  
[http://www.ihi.org/resources/Pages/Changes/ProvideFeedbacktoFrontLineStaff.aspx](http://www.ihi.org/resources/Pages/Changes/ProvideFeedbacktoFrontLineStaff.aspx)

Feedback to frontline staff is a critical component of demonstrating a commitment to safety and ensuring that staff members continue to report safety issues. This Institute for Healthcare Improvement Web site identifies tips and tools for providing feedback.
3. **Safety Huddle Results Collection Tool**  
http://www.ihi.org/resources/Pages/Tools/SafetyHuddleResultsCollectionTool.aspx

This tool can be used to aggregate data collected during tests of Safety Briefings. When first testing Safety Briefings, it is important to gather information about staff perceptions of value. However, this information need not be collected at every Briefing, but only at the beginning and the end of the test. If an organization then decides to permanently implement Safety Briefings, other data collection tools may be used to track important information such as issues raised by staff and opportunities to improve safety.

4. **University of Michigan Health System Patient Safety Toolkit: Disclosure Chapter**  
http://www.ihi.org/resources/Pages/Tools/UMichiganHealthSystemPatientSafetyToolkitDisclosureChapter.aspx

The Patient Safety Toolkit was developed by University of Michigan with the financial support of Blue Cross Blue Shield of Michigan Foundation. The toolkit was designed to build a foundation of knowledge and to suggest practical applications for developing best practices. A chapter is dedicated to the disclosure of medical errors or unanticipated outcomes.


1. **Appoint a Safety Champion for Every Unit**  
http://www.ihi.org/resources/Pages/Changes/AppointaSafetyChampionforEveryUnit.aspx

Having a designated safety champion in every department and patient care unit demonstrates the organization’s commitment to safety and may make other staff members feel more comfortable about sharing information and asking questions. This Institute for Healthcare Improvement Web site identifies tips for appointing a safety champion.

2. **Conduct Patient Safety Leadership WalkRounds™**  
http://www.ihi.org/resources/Pages/Changes/ConductPatientSafetyLeadershipWalkRounds.aspx

Senior leaders can demonstrate their commitment to safety and learn about the safety issues in their organization by making regular rounds to discuss safety issues with frontline staff. This Institute for Healthcare Improvement Web site discusses the benefits for management making regular rounds and provides links to tools available for download. One specific tool created by Dr. Allan Frankel is highlighted: [http://www.wsha.org/files/82/WalkRounds1.pdf](http://www.wsha.org/files/82/WalkRounds1.pdf).

3. **IHI Framework for Leadership for Improvement**  
http://www.ihi.org/resources/Pages/Tools/IHIFrameworkforLeadershipforImprovement.aspx

The Framework for Leadership for Improvement, developed by the Institute for Healthcare Improvement, was built upon the concepts of “Will, Ideas, and Execution.” It organizes leadership processes that focus the organization and senior leaders on improvement.
4. **Patient Safety Rounding Toolkit**  

The Patient Safety Rounding Toolkit is available to download from the Dana-Farber Cancer Institute. It provides resources for assessing whether an organization will benefit from patient safety rounds and for designing and implementing a patient safety rounds program.

5. **Partnership To Improve Dementia Care in Nursing Homes: State Coalition Provider Question Worksheet**  
[http://www.nhqualitycampaign.org/files/Partnership%20Provider%20Assessment%20Form%207%2027%2012.pdf](http://www.nhqualitycampaign.org/files/Partnership%20Provider%20Assessment%20Form%207%2027%2012.pdf)

This provider self-assessment contains a list of questions for direct caregivers and nursing home leadership to assist facilities in assessing their approach to dementia care.

**Dimension 5. Organizational Learning**

1. **AHRQ Health Care Innovations Exchange Learn & Network**  

How do you introduce innovations to your organization? How do you encourage others to think outside the box and accept new ideas? Browse the Learn & Network part of this site to find advice and ideas from experts and practitioners, insights from the literature, and opportunities to participate in discussions and learning networks on specific topics.

2. **Decision Tree for Unsafe Acts Culpability**  

The decision tree for unsafe acts culpability is a tool available for download from the Institute for Healthcare Improvement Web site. This decision tree can be used to analyze an error or adverse event that has occurred in an organization to help identify how human factors and systems issues contributed to the event. This decision tree is particularly helpful when working toward a nonpunitive approach.

3. **Guide to Implementing Quality Improvement Principles**  

This quality improvement guide for leaders to use to implement the principles of quality improvement. The principles of quality improvement can be applied to clinical care and organizational systems. The sections of this guide will explain general quality improvement principles followed by strategies for implementing quality improvement principles in your daily work.
4. Institute for Healthcare Improvement: Plan-Do-Study-Act (PDSA) Worksheet (IHI Tool)
http://www.ihi.org/resources/Pages/Tools/PlanDoStudyActWorksheet.aspx

The Plan-Do-Study-Act (PDSA) Worksheet is a useful tool for documenting a test of change. The PDSA cycle is shorthand for testing a change by developing a plan to test the change (Plan), carry out the test (Do), observe and learn from the consequences (Study), and determine what modifications should be made to the test (Act).

5. Mistake-Proofing the Design of Health Care Processes

This resource is featured on the AHRQ Health Care Innovations Exchange Web site. It is a synthesis of practical examples from the world of health care on the use of process or design features to prevent medical errors or the negative impact of errors. It contains more than 150 examples of mistake proofing that can be applied in health care and in many cases relatively inexpensively. In Mistake-Proofing the Design of Health Care Processes, risk managers and chief medical officers will benefit from common-sense approaches to reducing risk and litigation, and organizations will find the groundwork for a successful program that fosters innovation and creativity as they address their patient safety concerns and approaches.

6. National Nursing Home Quality Care Collaborative: Change Package

This change package is intended for nursing homes participating in the National Nursing Home Quality Care Collaborative led by the Centers for Medicare & Medicaid Services (CMS) and the Medicare Quality Improvement Organizations (QIOs), to improve care for the millions of nursing home residents across the country. The change package is focused on the successful practices of high performing nursing homes. It was developed from a series of ten site visits to nursing homes across the country, and the themes that emerged regarding how they approached quality and carried out their work. The practices in the change package reflect how the nursing homes leaders and direct care staff at these sites shared and described their efforts. The change package is a menu of strategies, change concepts, and specific actionable items that any nursing home can choose from to begin testing for purposes of improving residents’ quality of life and care.

7. Nursing Home Learning Collaborative Improves Quality of Care, Reduces Staff Turnover
http://www.innovations.ahrq.gov/content.aspx?id=259

This featured profile is available on the AHRQ Innovations Exchange Web site. In this approach to improving nursing home care, known as the Wellspring Model, nursing homes come together in a learning collaborative to exchange performance data and conduct group training for both staff and leadership on quality improvement processes.
8. Patient- and Family-Centered Care Organizational Self-Assessment Tool
http://www.ihi.org/resources/Pages/Tools/PatientFamilyCenteredCareOrganizationalSelfAssessmentTool.aspx

This tool was developed by the Institute for Healthcare Improvement (in collaboration with the National Initiative for Children's Healthcare Quality and the Institute for Patient- and Family-Centered Care). The self-assessment tool allows organizations to understand the range and breadth of elements of patient- and family-centered care and to assess where they are against the leading edge of practice. Use this self-assessment tool to assess how your organization is performing in relation to specific components of patient- and family-centered care, or as a basis for conversations about patient-centeredness in the organization.

9. Patient Safety Primer: Root Cause Analysis

Root Cause Analysis (RCA) is a structured method used to analyze adverse events. Initially developed to analyze industrial accidents, RCA is now widely deployed as an error analysis tool in health care. The AHRQ Patient Safety Network explains this topic further and provides links for more information on what is new in RCA.

10. Quality Improvement Fundamentals Toolkit

This toolkit was developed by the Oklahoma Foundation for Medical Quality and can be used to help identify opportunities for improvement and develop improvement processes.

11. A Systems Approach to Quality Improvement in Long-Term Care: Safe Medication Practices Workbook

This resource is featured on the AHRQ Health Care Innovations Exchange Web site. This manual provides nursing home staff with a step-by-step guide for medication management to reduce medication errors in long-term care.

12. VA National Center for Patient Safety – NCPS Root Cause Analysis
http://www.patientsafety.va.gov/professionals/onthejob/rca.asp

Since 1999, NCPS has developed tools, training, and software to facilitate patient safety and root cause analysis (RCA) investigations. This guide functions as a cognitive aid to help teams develop a chronological event flow diagram (an understanding of what occurred) along with a cause and effect diagram (why the event occurred). RCA teams have found this book an effective aid with these sometimes difficult activities.
The goal of this guide is to promote evidence-based decisionmaking and to help decisionmakers determine whether an innovation would be a good fit or an appropriate stretch for their health care organization.

**Dimension 6. Training and Skills**

1. **AHRQ Patient Safety Education and Training Catalog**

   The Patient Safety Education and Training Catalog consist of 333 patient safety programs available in the United States as of November 28, 2011. Developed by the American Institutes for Research (AIR) from internet searches in 2010 and 2011, the catalog captures a snapshot of available programs at the time. Because new programs are continually being developed, old ones retired, and others revised and improved, interested readers should check the relevant websites for up-to-date information.

2. **IMPACT (Improving Mood: Promoting Access to Collaborative Treatment for Late-Life Depression)**

   This tool was developed by the University of Washington, Psychiatry & Behavioral Science, and is featured on the AHRQ Health Care Innovations Exchange Web site. The IMPACT Tools page is an online resource of materials and information designed to help clinicians and organizations implement a model for depression care for older adults in a variety of settings. The program works to improve quality of life, physical and social functioning, and decrease pain among the elderly. Clinicians can learn skills by using a combination of audio-annotated PowerPoint presentations, streaming video, case studies, and reference manuals.

3. **Improving Patient Safety in Long-Term Care Facilities: Training Modules**
   [http://www.ahrq.gov/professionals/systems/long-term-care/resources/facilities/ptsafety/ltcmodule0.html](http://www.ahrq.gov/professionals/systems/long-term-care/resources/facilities/ptsafety/ltcmodule0.html)

   This training module is featured on the AHRQ Health Care Innovations Exchange Web site. The Improving Patient Safety in Long-Term Care Facilities: Training Modules materials are intended for use in training frontline personnel in nursing homes and other long-term care facilities. The materials were developed for the Agency for Healthcare Research and Quality (AHRQ) under a contract to the RAND Corporation. They are organized into three modules:
   - Module 1: Detecting Change in a Resident's Condition
   - Module 2: Communicating Change in a Resident's Condition
   - Module 3: Falls Prevention and Management
4. **SBAR Training Scenarios and Competency Assessment**

   [http://www.ihi.org/resources/Pages/Tools/SBARTrainingScenariosandCompetencyAssessment.aspx](http://www.ihi.org/resources/Pages/Tools/SBARTrainingScenariosandCompetencyAssessment.aspx)

   These SBAR training scenarios reflect a range of clinical conditions and patient circumstances, are used in conjunction with other SBAR training materials to assess front-line staff competency in using the SBAR technique for communication.

5. **Try This: Best Practices in Nursing Care to Older Adults**

   [http://consultgerirn.org/resources](http://consultgerirn.org/resources)

   This tool was developed by the Hartford Institute for Geriatric Nursing at New York University's College of Nursing, and is featured on the AHRQ Health Care Innovations Exchange Web site. "Try This" is a series of assessment tools where each issue focuses on a topic specific to the older adult population. The content is directed to orient and encourage all nurses to understand the special needs of older adults and to use the highest standards of practice in caring for older adults.

   Cross-reference to resources already described:

   - Reducing Pressure Ulcers, #9 [Pressure Ulcer Prevention: A Nursing Competency-Based Curriculum](http://www.ihi.org/resources/Pages/Tools/PressureUlcerPreventionACompetencyBasedCurriculum.aspx)
   - Reducing Pressure Ulcers, #13 [Staff Training and Support, Incentives, and Feedback Fails to Generate Sustainable Reductions in Pressure Ulcers at Nursing Home](http://www.ihi.org/resources/Pages/Tools/StaffTrainingandSupportIncentivesandFeedbackFailsToGenerateSustainableReductionsinPressureUlcersatNursingHome.aspx)
   - Reducing Pressure Ulcers, #14 [Pressure Ulcer Baseline Assessment Survey for Registered Nurses and Nursing Assistants](http://www.ihi.org/resources/Pages/Tools/PressureUlcerBaselineAssessmentSurveyforRegisteredNursesandNursingAssistants.aspx)
   - Dimension 3. Supervisor Expectations and Actions Promoting Resident Safety and Dimension 4. Management Support for Resident Safety, #5 [Partnership To Improve Dementia Care in Nursing Homes: State Coalition Provider Question Worksheet](http://www.ihi.org/resources/Pages/Tools/PartnershipToImproveDementiaCareinNursingHomesStateCoalitionProviderQuestionWorksheet.aspx)

**Dimension 7. Compliance With Procedures**

1. **Hand Hygiene in Outpatient Care, Home-Based Care, and Long-Term Care Facilities**

   [http://www.who.int/gpsc/5may/EN_GPSC1_PSP_HH_Outpatient_care/en/index.html](http://www.who.int/gpsc/5may/EN_GPSC1_PSP_HH_Outpatient_care/en/index.html)

   To respond to the demand from national representatives and stakeholders around the world, the WHO Clean Care is Safer Care team has launched the new WHO Guide on Hand Hygiene in Outpatient and Home-based Care and Long-term Care Facilities. The main objective of the guide is provide conceptual and practical guidance on the application of the WHO Multimodal Hand Hygiene Improvement Strategy and the My Five Moments approach in health-care settings where patients are not admitted as inpatients to a hospital.

2. **Healthcare Provider Toolkit**

   [http://www.oneandonlycampaign.org/content/healthcare-provider-toolkit](http://www.oneandonlycampaign.org/content/healthcare-provider-toolkit)

   This toolkit will assist individuals and organizations with educating healthcare providers and patients about safe injection practices. Any healthcare provider that gives injections (in the form of medication, vaccinations, or other medical procedures) should be aware of safe injection
practices. Partners of the Safe Injection Practices Coalition (SIPC) helped to create the materials in this toolkit and distribute these materials throughout their individual organizations.

3. **How-To Guide: Improving Hand Hygiene**
   [http://www.ihi.org/resources/Pages/Tools/HowtoGuideImprovingHandHygiene.aspx](http://www.ihi.org/resources/Pages/Tools/HowtoGuideImprovingHandHygiene.aspx)

   The purpose of this How-to Guide is to help organizations reduce healthcare-associated infections, including infections due to antibiotic-resistant organisms, by improving hand hygiene practices and use of gloves among health care workers. The guide includes:
   
   - A description of the case for improving hand hygiene and use of gloves among health care workers
   - Recommended evidence-based interventions that will result in improvement
   - How to begin improving hand hygiene compliance in your organization, including establishing a team, setting aims, testing changes, and measuring results
   - Measurement support tools

4. **Long-Term Care Toolkit**

   This toolkit is designed to help health care providers in long-term care facilities implement the 12 Steps to Prevent Antimicrobial Resistance Among Long-Term Care Residents, a set of recommendations developed by the Centers for Disease Control and Prevention (CDC) as part of its Campaign to Prevent Antimicrobial Resistance in Healthcare Settings. The toolkit follows the CDC 12-step framework and is divided into 12 sections, one for each step in the CDC Campaign. Strategies on how to break specific links in the chain of infection are included in each step, along with practical information, protocols, policies, and tools designed to be easily customized for specific facility needs.

5. **Medication Reconciliation Flowsheet**
   [http://www.ihi.org/resources/Pages/Tools/MedicationReconciliationFlowsheet.aspx](http://www.ihi.org/resources/Pages/Tools/MedicationReconciliationFlowsheet.aspx)

   Medication reconciliation reviews may be conducted during the admission process, often by nurses on the admission unit, to identify unreconciled medications and potential errors or adverse events. This flowsheet helps nursing personnel perform a medication reconciliation process when patients are admitted to an intermediate care unit, either directly or as transfers from other inpatient care units.

6. **Medication Reconciliation Review: Data Collection Form**
   [http://www.ihi.org/resources/Pages/Tools/MedicationReconciliationReviewDataCollectionForm.aspx](http://www.ihi.org/resources/Pages/Tools/MedicationReconciliationReviewDataCollectionForm.aspx)

   This form was designed at Luther Midelfort Hospital for staff to use as part of the medication reconciliation review process. The Medication Reconciliation Review provides instructions for conducting the review of closed patient records. Data recorded with the Medication Reconciliation Form can be aggregated and monitored over time, as part of an ongoing
improvement effort. Detailed instructions for using the form are provided in the Medication Reconciliation Review.

7. Medication Safety Reconciliation Toolkit
http://www.ihi.org/resources/Pages/Tools/MedicationSafetyReconciliationToolKit.aspx

The toolkit provides extensive detail on where and how to reconcile medications at all transition points of care; how to implement medication reconciliation process; and provides sample process maps, algorithms, and forms. The tool also provides some resources from the Institute for Healthcare Improvement, such as the Mentor Hospital list of hospitals that are implementing medication reconciliation as part of IHI's 5 Million Lives Campaign intervention.

8. Nursing Assessment Form With Medical Emergency Team (MET) Guidelines
http://www.ihi.org/resources/Pages/Tools/NursingAssessmentFormwithMETGuidelines.aspx

This Nursing Assessment Form includes guidelines for when to activate the Medical Emergency Team (MET). The MET activation guidelines are included on all Medical-Surgical flow sheets as a reminder to activate the MET if any of the abnormal signs or symptoms are present. This allows the floor nurses to identify criteria for activating the MET response and allows the MET nurse to provide early expertise assessment and intervention.

Dimension 8. Teamwork

1. GRACE Interdisciplinary Team Suggestions
https://static.medicine.iupui.edu/divisions/iucar/content/graceteamsuggestions.pdf

This guide is featured on the AHRQ Health Care Innovations Exchange Web site. The GRACE (Geriatric Resources for Assessment and Care of Elders) Interdisciplinary Team Suggestions guide health care providers as they develop and implement individualized care plans for low-income seniors to improve quality of care. The tools are based on the GRACE model, which uses nurse practitioners and social workers who work together as a support team, first meeting with low-income seniors to conduct a comprehensive geriatric assessment, and then with a larger interdisciplinary team to develop an individualized, integrated care plan based on this set of protocols for evaluating and managing common geriatric conditions. The support team works with the patient's primary care physician (PCP) to modify, finalize, and implement the plan.

2. Healthcare Team Vitality Instrument
http://www.ihi.org/resources/Pages/Tools/HealthcareTeamVitalityInstrument.aspx

This tool was developed as part of the initiative, Transforming Care at the Bedside, a national program of the Robert Wood Johnson Foundation and the Institute for Healthcare Improvement The Healthcare Team Vitality Instrument (HTVI) measures team vitality with an emphasis on dimensions related to front-line staff empowerment and engagement, perception of a work environment supportive of safe and high-quality patient care, effective communication, and team collaboration. The HTVI was initially developed to assess team vitality of nurses and other personnel working on inpatient medical-surgical units. The tool has been adapted based upon validation research.
3. **Patient Safety Primer: Teamwork Training**  
http://psnet.ahrq.gov/primer.aspx?primerID=8

Providing safe health care depends on highly trained individuals with disparate roles and responsibilities acting together in the best interests of the patient. The AHRQ Patient Safety Network explains this topic further and provides links for more information on what is new in teamwork training.

4. **Patient Safety Through Teamwork and Communication Toolkit**  

This toolkit is featured on the AHRQ Health Care Innovations Exchange Web site. It consists of an education guide and communication tools. The education guide provides a plan for the education and integration of communication and teamwork factors into clinical practice. The communication tools section provides a description of each of the following tools along with provisions for implementation: Multidisciplinary Rounding, Huddles, Rapid Response and Escalation and Structured Communication.

5. **TeamSTEPPS® - Team Strategies and Tools to Enhance Performance and Patient Safety**  

Developed jointly by the Department of Defense (DoD) and the Agency for Healthcare Research and Quality (AHRQ), TeamSTEPPS™ is a resource for training health care providers in better teamwork practices. The training package capitalizes on DoD’s years of experience in medical and nonmedical team performance and AHRQ’s extensive research in the fields of patient safety and health care quality. Following extensive field testing in the Military Health System (MHS) and several civilian organizations, a multimedia TeamSTEPPS toolkit is now available in the public domain to civilian health care facilities and medical practices.

http://www.psqh.com/novdec06/ahrq.html

This article provides background information on TeamSTEPPS (Team Strategies and Tools to Enhance Performance and Patient Safety), a resource for training healthcare providers in better teamwork practices, developed jointly by the Department of Defense (DoD) and the Agency for Healthcare Research and Quality (AHRQ).

7. **TeamSTEPPS Rapid Response Systems (RRS) Training Module**  
http://www.ahrq.gov/professionals/education/curriculum-tools/teamstepps/rrs/

This evidence-based module provides insight into the core concepts of teamwork as they are applied to the rapid response system (RRS). The module contains the Instructor Guide in electronic form plus training slides that include a high-quality video vignette of teamwork as it relates to RRS. This comes as a CD-ROM with the printable files (Word®, PDF, and PowerPoint®).
8. TeamSTEPPS Readiness Assessment Tool
http://teamstepps.ahrq.gov/readiness/

Answering these questions can help your institution understand its level of readiness to initiate the TeamSTEPPS program. You may find it helpful to have a colleague review your responses or to answer the questions with a larger group (e.g., senior leaders).

**Dimension 9. Handoffs**

1. Cooperative Network Improves Patient Transitions Between Hospitals and Skilled Nursing Facilities, Reducing Readmissions and Length of Hospital Stays
http://www.innovations.ahrq.gov/content.aspx?id=2162

This featured profile is available on the AHRQ Health Care Innovations Exchange Web site. Summa Health System’s Care Coordination Network strives to ensure smooth transitions between the hospitals and 37 local skilled nursing facilities, leading to fewer readmissions and lower length of stay in the hospital.

2. Handoff of Care Frequently Asked Questions

This resource from the University of Virginia Health System identifies a strategy to improve handoff communication called IDEAL (Identify, Diagnosis, Events, Anticipate, Leave).

3. How-To Guide: Improving Transitions From the Hospital to Skilled Nursing Facilities To Reduce Avoidable Rehospitalizations
http://www.ihi.org/resources/Pages/Tools/HowtoGuideImprovingTransitionHospitalSNFstoReduceRehospitalizations.aspx

This guide was developed by the Institute for Health Care Improvement to support teams in skilled nursing facilities (SNFs) and their community partners in code-signing and reliably implementing improved care processes to ensure that residents have a safe, effective transition into — and are actively received by — the SNF (an umbrella term representing different types of post-acute care settings, including nursing homes, skilled nursing care centers, long-term care facilities, rehabilitation facilities, post-acute care facilities, and complex or convalescent care centers in Canada).

4. How-To Guide: Prevent Adverse Drug Events (Medication Reconciliation)
http://www.ihi.org/resources/Pages/Tools/HowtoGuidePreventAdverseDrugEvents.aspx

This guide describes key evidence-based care components to prevent adverse drug events (ADEs) by implementing medication reconciliation at all transitions in care (at admission, transfer, and discharge), describes how to implement these interventions, and recommends measures to gauge improvement. The guide was initially developed as part of IHI's 5 Million Lives Campaign.
5. Interventions To Reduce Acute Care Transfers (INTERACT)  
http://interact2.net

INTERACT is a quality improvement program designed to improve the early identification, assessment, documentation, and communication about changes in the status of residents in skilled nursing facilities. The goal of INTERACT is to improve care and reduce the frequency of potentially avoidable transfers to the acute hospital. Such transfers can result in numerous complications of hospitalization, and billions of dollars in unnecessary health care expenditures.

6. Medications At Transitions and Clinical Handoffs (MATCH) Initiative  

This toolkit is featured on the AHRQ Health Care Innovations Exchange Web site. The goal of the MATCH Initiative is to measurably decrease the number of discrepant medication orders and the associated potential and actual patient harm. This toolkit is designed to assist all types of organizations, whether caring for inpatients or outpatients or using an electronic medical record, a paper-based system, or both.

7. Post-Acute Transfer Form  
http://www.commonwealthfund.org/usr_doc/TransferForm.pdf?section=4039

This profile is available on the AHRQ Health Care Innovations Exchange Web site. This form is used to standardize information transferred between acute care hospitals and skilled nursing facilities throughout the four-county northeastern Ohio region. It may be adapted for use in other areas. It includes information on medications, activities of daily living, orders, and special care needs.

8. “Same Page” Transitional Care Resources for Patients and Care Partners  
http://www.ihi.org/resources/Pages/Tools/SamePageTransitionalCareResourcesforPatientsandCarePartners.aspx

These resources and tools were developed for patients and their caregivers or care partners to use when planning for care or during a stay in a hospital or skilled nursing facility. The goal is to support patients, their care partners, and the team of health care providers to all be “on the same page” in understanding the patient’s health and health care needs when the patient is transitioning from one setting of care to another. The tools include surveys to fill out before and after a patient’s stay as well as specific resources designed to support care partners. The Planetree Same Page Patient Notebook includes detailed information and tools that are designed to be useful to patients, care partners, and the health care team.

9. Your Discharge Planning Checklist: For Patients and Caregivers Preparing To Leave a Hospital, Nursing Home, or Other Health Care Setting  
http://www.medicare.gov/Publications/Pubs/pdf/11376.pdf

This profile is available on the AHRQ Health Care Innovations Exchange Web site. This patient handout can help patients, caregivers, and medical staff communicate as patients prepare to leave a hospital, nursing home, or other health care setting. The booklet provides many questions and
prompts for patients and caregivers so that they can gather information to ensure a safe discharge.

**Dimension 10. Communication Openness**

1. Rapid Response Team Record With SBAR
   [http://www.ihi.org/resources/Pages/Tools/RapidResponseTeamRecordwithSBAR.aspx](http://www.ihi.org/resources/Pages/Tools/RapidResponseTeamRecordwithSBAR.aspx)

   Both the primary nurse for the patient and the Rapid Response Team nurse have responsibility for completing the form when a Rapid Response Team call is initiated. The form then becomes a permanent part of the patient’s medical record. The Rapid Response Team record includes approved protocol orders that may be initiated by the Rapid Response Team nurse. The SBAR (Situation-Background-Assessment-Recommendation) tool is printed on the back of the form and is used as a guide for the primary nurse when calling the physician to ensure that concise, pertinent information is reported.

2. SBAR Technique for Communication: A Situational Briefing Model
   [http://www.ihi.org/resources/Pages/Tools/SBARTechniqueforCommunicationASituationalBriefingModel.aspx](http://www.ihi.org/resources/Pages/Tools/SBARTechniqueforCommunicationASituationalBriefingModel.aspx)

   - The SBAR (Situation-Background-Assessment-Recommendation) technique provides a framework for communication between members of the health care team about a patient’s condition. This downloadable tool from the Institute for Healthcare Improvement contains two documents.
   - SBAR Report to Physician About a Critical Situation is a worksheet/script that a provider can use to organize information in preparing to communicate with a physician about a critically ill patient. —Guidelines for Communicating With Physicians Using the SBAR Process explains how to carry out the SBAR technique.


   These two surveys were developed by the Advocate Good Samaritan Hospital. The surveys can be utilized to better understand nurse and physician experiences with and attitudes about communicating/collaborating with each other and highlight areas that present the greatest opportunity for improvement.

Cross-reference to resource already described:

- Dimension 8. Teamwork, # 4 [Patient Safety Through Teamwork and Communication Toolkit](http://www.ihi.org/resources/Pages/Tools/PatientSafetyThroughTeamworkandCommunicationToolkit.aspx)
Dimension 11. Nonpunitive Response to Mistakes

1. Call to Action: Safeguarding the Integrity of Healthcare Quality and Safety Systems

   The NAHQ’s Call to Action: Safeguarding the Integrity of Healthcare Quality and Safety Systems, provides best practices to enhance quality, improve ongoing safety reporting and protect staff. It addresses accountability, protection of those who report quality and safety concerns, and accurate reporting and response.

2. Leadership Response to a Sentinel Event: Respectful, Effective Crisis Management
   http://www.ihi.org/resources/Pages/Tools/LeadershipResponseSentinelEventEffectiveCrisisMgmt.aspx

   This tool was developed by the Institute for Healthcare Improvement (IHI). IHI periodically receives urgent requests from organizations seeking help in the aftermath of a serious organizational event, most often a significant medical error. In responding to such requests, IHI has drawn on learning and examples assembled from many courageous organizations over the last 15 years who have respectfully and effectively managed these crises.

3. Living a Culture of Patient Safety Policy and Brochure
   http://www.ihi.org/resources/Pages/Tools/LivingaCultureofPatientSafety.aspx

   St. John's Mercy Medical Center created an institution-wide policy regarding non-punitive reporting, as well as a brochure entitled Living a Culture of Patient Safety that was developed by its Culture of Safety Subcommittee, signed by the president, and mailed to all co-worker homes. The brochure reinforces the non-punitive reporting policy and encourages all co-workers to report errors.

4. “Nonpunitive Response to Error”: The Fair and Just Principles of the Aurora Culture

   This presentation from the AHRQ Surveys on Patient Safety Culture User Group Meeting describes Aurora Health Care’s approach to creating a culture of safety and reviews the action steps taken to address the —Nonpunitive Response to Error dimension in the survey.

5. Patient Safety and the “Just Culture”: A Primer for Health Care Executives

   Accountability is a concept that many leaders wrestle with as they steer their organizations and patients toward understanding and accepting the idea of a blameless culture within the context of medical injury. This report by David Marx is available for download through the AHRQ Patient Safety Network and outlines the complex nature of deciding how best to hold individuals accountable for mistakes.
6. **Patient Safety and the “Just Culture”: A Presentation by David Marx, J.D.**


   This presentation on Patient Safety and the Just Culture by David Marx defines just culture, the safety task, the just culture model, and statewide initiatives in New York.

   Cross-references to resources already described:

   - Dimension 5. Organizational Learning, #2 Decision Tree for Unsafe Acts Culpability.
   - Dimension 10. Communication Openness, #2 SBAR Technique for Communication: A Situational Briefing Model.

### Dimension 12. Staffing

1. **Creation of Households Program in Nursing Home Improves Residents’ Health Status, Reduces Staff Turnover, and Boosts Demand for Services**

   http://innovations.ahrq.gov/content.aspx?id=2051

   This featured profile is available on the Agency for Healthcare Research and Quality’s Innovations Exchange Web site. Meadowlark Hills, a retirement community, renovated one of its facilities, so that residents can live together in group households and become more independent. The innovator noted that the change in approach led to improvements in residents’ health, a sharp decrease in staff turnover, and a significant increase in demand for facility services, all without raising operating costs.

2. **Just In Time Toolkits for Staffing Transformation**

   https://www.pioneernetwork.net/Providers/JustInTime/Staffing

   This toolkit is the Pioneer Network’s comprehensive list of tools to assist nursing homes in various aspects of staffing, culture change, and quality improvement activities that are important to improving care for residents with dementia.

3. **Workforce Strategies: Introducing Peer Mentoring in Long-Term Care Settings**

   http://www.directcareclearinghouse.org/download/WorkforceStrategies2.pdf

   This article identifies the benefits of peer mentoring in long-term care settings for staff retention and provides instructions on how to design a peer mentoring program.

   Cross-reference to resource already described:

   - Dimension 5. Organizational Learning, #8 Nursing Home Learning Collaborative Improves Quality of Care, Reduces Staff Turnover.