Improving Patient Safety in Community Pharmacies: A Resource List for Users of the AHRQ Community Pharmacy Survey on Patient Safety Culture

Purpose

This document contains references to Web sites that provide practical resources community pharmacies 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 pharmacies looking for information about patient safety initiatives. This document will be updated periodically.

How To Use This Resource List

General resources are listed first, in alphabetical order, followed by resources organized by the dimensions assessed in the Agency for Healthcare Research and Quality (AHRQ) Community Pharmacy Survey on Patient Safety Culture.

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), 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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General Resources

1. **30 Safe Practices for Better Health Care Fact Sheet**

   This fact sheet is featured on AHRQ’s Health Care Innovations Exchange Web site. 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.

2. **AHRQ Health Care Innovations Exchange**

   AHRQ’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 the Agency’s mission to improve the safety, effectiveness, patient centeredness, timeliness, efficiency, and equity of care. It emphasizes 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
   - Events and podcasts
   - Videos
   - Learning and networking opportunities
   - Articles and guides

3. **AHRQ Patient Safety Organization**

   The AHRQ Patient Safety Organization (PSO) Web site is designed to give you an understanding of the:
   
   - Purpose and goals of PSOs.
   - Protections offered by PSOs.
   - Process for becoming a PSO.
   - Information on listed PSOs.
   - Common Formats for reporting patient safety events.

4. **AHRQ Medical Errors and Patient Safety**

   The AHRQ Medical Errors and Patient Safety Web site provides links to various fact sheets, including information on how to improve health care quality and reduce and prevent adverse drug events. It also contains patient safety research highlights and other related topics.
5. **AHRQ Patient Safety Network**

AHRQ 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, PSNet provides searching and browsing capability and allows users to customize the site around their interests (My PSNet). It also is tightly coupled with AHRQ’s WebM&M, the popular monthly journal that features user-submitted cases of medical errors, expert commentaries, and perspectives on patient safety.

6. **Automated Telephone Reminders: A Tool to Help Refill Medicines on Time**

This easy-to-understand telephone script is provided for use by pharmacies that want to provide automated refill reminder calls to patients.

7. **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.

8. **Chasing Zero: Winning the War on Health Care Harm**

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.

9. **The Commonwealth Fund**

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. The organization focuses on society’s most vulnerable populations, including low-income people, uninsured people, minority groups, young children, and older adults. The Commonwealth Fund provides information on a variety of health care topics, as well as free publications and innovations and tools for improving health care.
10. Consumers Advancing Patient Safety
http://www.patientsafety.org/

Consumers Advancing Patient Safety 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.

11. ConsumerMedSafety.org
http://www.consumermedsafety.org/

ConsumerMedSafety.org is designed to help consumers avoid mistakes when taking medicines. Most of the material on the Web site is written by staff from the Institute for Safe Medication Practices and includes medication safety articles, tools and resources, latest Food and Drug Administration medication alerts, and a form to report a medication error.

12. 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.

13. Institute for Healthcare Improvement
http://www.ihi.org/

The Institute for Healthcare Improvement (IHI) is a reliable source of energy, knowledge, and support for an ongoing campaign to improve health care worldwide. IHI helps accelerate change in health care by cultivating promising concepts for improving patient care and turning those ideas into action.

http://www.ismp.org/

The Institute for Safe Medication Practices (ISMP) is a nonprofit organization educating the health care community and consumers about safe medication practices. It is certified by AHRQ as a Patient Safety Organization. ISMP features newsletters, webinars, tools, and educational materials and allows health care practitioners and consumers to report errors through two national error-reporting programs: the National Medication Errors Reporting Program and the National Vaccine Errors Reporting Program.
15. **The Joint Commission: Patient Safety**  
[http://www.jointcommission.org/topics/patient_safety.aspx](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.

16. **National Association of Boards of Pharmacy (NABP) PMP InterConnect®**  

NABP PMP InterConnect® is a data exchange platform that links prescription monitoring programs operated by various States, allowing authorized users, including health care practitioners and pharmacists, access to patient-specific controlled substance prescription information from across State lines. After signing a memorandum of understanding with the association, State-run prescription monitoring programs implement an interface with NABP InterConnect. Authorized users log into their State’s prescription monitoring program, enter a patient’s name, and receive a single report summarizing that patient’s drug-seeking activities in all participating States. They then use this information to assist in identifying patients who appear to be crossing State lines to obtain drugs for potential personal misuse or drug diversion (the transfer of drugs from lawful to illegal purposes). The program has enhanced access to interstate prescription monitoring program data for authorized users in 15 States who have collectively accessed the system more than 2 million times since its implementation.

17. **National Center for Patient Safety**  

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

18. **National Patient Safety Foundation®**  
[www.npsf.org/](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 dedicated to uniting disciplines and organizations across the continuum of care, championing a collaborative, inclusive, multistakeholder approach.
19. National Quality Forum  
http://www.qualityforum.org/Topics/Patient_Safety.aspx

The National Quality Forum 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.

20. 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, 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.

21. 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., medication errors, adverse drug reaction), discipline, audience, and patient safety focus.

22. A Toolset for E-Prescribing Implementation in Independent Pharmacies  
http://healthit.ahrq.gov/health-it-tools-and-resources/implementation-toolsets-e-prescribing/toolset-e-prescribing-0

This toolset is designed to assist pharmacies in adopting e-prescribing. It consists of seven chapters that provide guidance on various implementation topics and tools that can facilitate the implementation process.

23. World Health Organization Department of Essential Medicines and Health Products  

The World Health Organization Department of Essential Medicines and Health Products provides information on the following areas of work related to medicine: policy, governance, and country collaboration; quality assurance and safety; medicine access and rational use; medical devices and diagnostics; quality, safety, and standards for vaccines. The Web site features publications and training resources.
24. WhyNotTheBest?
http://whynotthebest.org/contents/

WhyNotTheBest.org 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.

**Resources by Dimension**

The following resources are organized according to the relevant Pharmacy 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. Physical Space and Environment**

1. **Improvement Report: Lean Thinking Applied to Pharmacy Processes**
http://www.ihi.org/resources/Pages/ImprovementStories/MemberReportLeanThinkingAppliedtoPharmacyProcesses.aspx

This improvement report on the Institute for Healthcare Improvement Web site identifies changes made to the physical space in the pharmacy department and the implementation of Lean Thinking methodology and tools to reduce turnaround time for medications and decrease errors.

http://www.ismp.org/Survey/NewMssacap/Index.asp

This self-assessment is a comprehensive tool designed to help health care providers and their staff assess the safety of medication practices in their pharmacy, identify opportunities for improvement, and compare their experience with the aggregate experiences of demographically similar community pharmacies around the Nation. It is divided into the following 10 elements:

- Patient information
- Drug information
- Communication of drug orders and other drug information
- Drug labeling, packaging, and nomenclature
- Drug standardization, storage, and distribution
- Use of devices
- Environmental factors
- Staff competency and education
- Patient education
- Quality process and risk management
3. Using Change Concepts for Improvement
http://www.ihi.org/resources/Pages/Changes/UsingChangeConceptsforImprovement.aspx

A change concept is a general notion or approach to change that has been found to be useful in developing specific ideas for changes that lead to improvement. This Institute for Healthcare Improvement Web page outlines change concepts such as error proofing, optimizing inventory, and improving workflow.

**Dimension 2. Teamwork**

1. **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 Primer explains this topic further and provides links for more information on what is new in teamwork training.

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

This toolkit consists of an education guide and communication tools. The education guide provides a plan for education and integration of communication and teamwork factors into clinical practice. The communication tools section describes each of the following tools and provisions for implementation:

- Multidisciplinary Rounding
- Huddles
- Rapid Response and Escalation
- Structured Communication

3. **TeamSTEPPS®—Team Strategies and Tools to Enhance Performance and Patient Safety**

Developed jointly by the Department of Defense (DoD) and 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 and several civilian organizations, a multimedia TeamSTEPPS toolkit is now available in the public domain to civilian health care facilities and medical practices. Additional TeamSTEPPS tools are in development.
4. TeamSTEPPS® Readiness Assessment Tool
http://teamstepps.ahrq.gov/readiness/

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

**Dimension 3. Staff Training and Skills**

1. AHRQ Patient Safety Education and Training Catalog

The AHRQ Patient Safety Education and Training Catalog consists of more than 300 patient safety programs currently available in the United States. The catalog offers an easily navigable database of patient safety education and training programs consisting of a robust collection of information each tagged for easy searching and browsing. The new database identifies a number of characteristics of the programs, including clinical area, program and learning objectives, evaluation measures, and cost. The clinical areas in the database align with the PSNet Collections.

2. Strategies To Improve Communication Between Pharmacy Staff and Patients: Training Program for Pharmacy Staff

This training program is designed to introduce pharmacists to the problem of low health literacy in patient populations and to identify the implications of this problem for the delivery of health care services. The program also explains techniques that pharmacy staff members can use to improve communication with patients who may have limited health literacy skills.

3. Tobacco Cessation Counseling: A Protocol for Practicing Pharmacists
http://media.ashp.org/tobacco/ (multimedia file; may not be accessible to users with disabilities)

This slide show is a cessation intervention course that pharmacists and clinicians can take and earn free continuing education credit. The objectives of this course are:

- Describe a new, redefined role for the pharmacist in the tobacco cessation process, positioning them as the initiator of the quit, not solely as the provider of services.
- Summarize how the pharmacist can serve as a motivator and educator for cessation.
- Explain the importance of pharmacists referring all patients to appropriate intensive interventions after initiating the cessation process.
4. **Working Together to Manage Diabetes: A Guide for Pharmacy, Podiatry, Optometry, and Dental Professionals**

Working Together to Manage Diabetes is a cross-training document developed by the National Diabetes Education Program’s Pharmacy, Podiatry, Optometry, and Dental Professionals’ Work Group. The goal is to reinforce consistent diabetes messages across the four disciplines of pharmacy, podiatry, optometry, and dentistry and to promote a team approach to comprehensive diabetes care that encourages collaboration among all care providers.

**Dimension 4. Communication Openness**

1. **SBAR Technique for Communication: A Situational Briefing Model**
   http://www.ihi.org/resources/Pages/Tools/SBARTechniqueforCommunicationASituationalBriefingModel.aspx

   The SBAR technique provides a framework for communication between members of the health care team about a patient’s condition. This tool from IHI has two documents. The first, “SBAR Report to Physician About a Critical Situation,” is a worksheet/script a provider can use to prepare to communicate with a physician about a critically ill patient. The second, “Guidelines for Communicating With Physicians Using the SBAR Process,” details how to carry out the SBAR technique.

   Cross-references to resource already described:
   - Dimension 2. Teamwork, #2 Patient Safety Through Teamwork and Communication Toolkit.

**Dimension 5. Patient Counseling**

1. **AHRQ Pharmacy Health Literacy Center**

   AHRQ Pharmacy Health Literacy Center provides pharmacists with recently released health literacy tools, curricular modules for pharmacy faculty, and resources for pharmacists interested in understanding more about health literacy.

2. **Implementing MTM in your Practice**
   http://www.pharmacist.com/implementing-mtm-your-practice

   The American Pharmacists Association outlines resources to support medication therapy management (MTM) services, including getting your MTM business started and inspiration and ideas from colleagues.
3. Medications at Transitions and Clinical Handoffs (MATCH) Toolkit for Medication Reconciliation
This AHRQ toolkit provides a step-by-step guide to improving the medication reconciliation process and includes guidelines, flowcharts, modifiable templates, and lessons learned.

4. National Council on Patient Information and Education
http://talkaboutrx.org
The National Council on Patient Information and Education Web site features educational resources and programs designed to stimulate and improve communication of information on the appropriate use of medicines to consumers and health care professionals.

5. Patient Outreach Tools
http://www.pharmacist.com/tools-patient-outreach
The American Pharmacists Association features a number of patient outreach tools that include information on national campaigns and initiatives to help pharmacies educate patients on important topics such as disposal of medications, poison control, diabetes, and physical activity.

6. Pharmacists Support Employees and Physicians in Managing Chronic Conditions, Leading to Better Care and Disease Control, Lower Costs, and Higher Productivity
http://www.innovations.ahrq.gov/content.aspx?id=3380
Using a model known as medication therapy management, which is often sponsored by employers, a program manager assigns participants to care managers (typically pharmacists) to provide ongoing chronic care management support to employees/covered dependents and their physicians. The goal is to improve care processes and patient self-management skills related to diabetes, asthma, cardiovascular risk factors, and depression. Sponsoring employers create financial incentives for participation, typically through lower or waived copayments for drugs and supplies or reductions in the employee share of the premium. Care managers meet regularly with individual enrollees to support their self-management and contact their physician as needed to suggest treatment changes. Originally pioneered in Asheville, North Carolina, for city employees (and hence known as the Asheville Project) and now implemented by employers throughout the Nation, the program has improved adherence to recommended care and self-management behaviors, leading to better disease control, lower costs, higher productivity, and a significant return on investment.
7. **The PROTECT Initiative: Advancing Children’s Medication Safety**

   The PROTECT Initiative is an innovative collaboration bringing together public health agencies, private sector companies, professional organizations, consumer/patient advocates, and academic experts to develop strategies to keep children safe from unintentional medication overdoses. Medication overdoses can lead to harm, sometimes requiring emergency treatment or hospitalization and are a significant public health problem. Over-the-counter and prescription medications are commonly used for people of all ages. This frequency of use increases the potential for unintentional overdoses. Children are especially vulnerable to unintentional overdoses, most of which can be prevented.

8. **Team Up. Pressure Down.**
   [http://millionhearts.hhs.gov/resources/teamuppressuredown.html](http://millionhearts.hhs.gov/resources/teamuppressuredown.html)

   Team Up. Pressure Down is a nationwide program to lower blood pressure and prevent hypertension through patient-pharmacist engagement. The videos and resources on this page can help patients, pharmacists, and health care providers better understand high blood pressure and the steps they can take to prevent or treat it. Team Up. Pressure Down was developed through the Million Hearts® Initiative sponsored by the U.S. Department of Health and Human Services.

9. **With Support From Web-Based Tools, Pharmacists Help Individuals Adopt Healthier Behaviors, Reduce Cardiovascular Risk**

   This featured profile is available on AHRQ’s Health Care Innovations Exchange Web site. Under a program known as HealthyHeartClub.com, pharmacists work with individuals with or at risk for heart disease, educating them on ways to reduce cardiovascular risk and helping them set and reach goals related to health outcomes and health-related behaviors, including diet, physical activity, and medication adherence. Designed to support primary care providers’ work with patients, the program consists of pharmacists conducting an initial in person consultation, weekly check-ins via e-mail, and monthly group classes, supported by a patient-friendly Web site that provides easy-to-understand information and tools to track progress toward established goals.

Cross-reference to resources already described:

- Dimension 3. Staff Training and Skills, #2 [Strategies To Improve Communication Between Pharmacy Staff and Patients: Training Program for Pharmacy Staff](http://www.cdc.gov/medicationsafety/protect/protect_initiative.html)
- Dimension 3. Staff Training and Skills, #3 [Tobacco Cessation Counseling: A Protocol for Practicing Pharmacists](http://www.cdc.gov/medicationsafety/protect/protect_initiative.html)
Dimension 6. Staffing, Work Pressure, and Pace

1. Beating Behind-the-Counter Job Stress

   Heavy workloads and long hours make stress management a critical skill for pharmacists. With a basic knowledge of coping strategies, pharmacists can overcome stress to achieve their personal best. This feature in Pharmacy Times defines stress in the pharmacy and identifies possible solutions for handling the stress.

2. Deflect Distractions and Intercept Interruptions
   http://www.pharmacist.com/node/206033

   This Institute for Safe Medication Practices error alert focuses on interruptions and distractions. The American Pharmacists Association discusses the effects of interruptions and distractions, their sources, and strategies to help decrease distractions.

Dimension 7. Communication About Prescriptions Across Shifts

Cross-reference to resource already described:

- Dimension 4. Communication Openness, #2 SBAR Technique for Communication: A Situational Briefing Model

Dimension 8. Communication About Mistakes

1. Provide Feedback to Frontline Staff
   http://www.ihi.org/resources/Pages/Changes/ProvideFeedbacktoFrontLineStaff.aspx

   Feedback to frontline staff is critical in demonstrating a commitment to safety and ensuring that staff members continue to report safety issues. This Institute for Healthcare Improvement Web page identifies tips and tools for communicating feedback.

Dimension 9. Response to Mistakes

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

   The National Association for Healthcare Quality 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. **Decision Tree for Unsafe Acts Culpability**
   http://www.ihi.org/resources/Pages/Tools/DecisionTreeforUnsafeActsCulpability.aspx (requires free account setup and login)

The decision tree for unsafe acts culpability is a tool available for download from the Institute for Healthcare Improvement Web site. Staff can use this decision tree when analyzing an error or adverse event in an organization to help identify how human factors and system issues contributed to the event. This decision tree is particularly helpful when working toward a nonpunitive approach in an organization.

3. **Patient Safety and the “Just Culture”**

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

4. **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.

**Dimension 10. Organizational Learning—Continuous Improvement**

5. **AHRQ Health Care Innovations Exchange Learn & Network**
   http://www.innovations.ahrq.gov/learn_network.aspx

This part of the Health Care Innovations Exchange Web site has information on how to introduce innovations to an organization and how to encourage others to think “outside the box” and accept new ideas. Learn & Network has tools and resources on specific topics such as community care coordination and building relationships between clinical practices and the community to improve care.

6. **High-Alert Medication Modeling and Error-Reduction Scorecards (HAMMERS) for Community Pharmacies**

This free toolkit was developed to help community pharmacies identify risk factors within the dispensing process, provide estimates of the impact of each risk factor, estimate how often an error or adverse drug event reaches a patient, assess how these risks may affect patients, and implement strategies to prevent errors. By using this tool, pharmacists can estimate how often prescribing and dispensing errors reach patients and how the frequency will change if certain interventions are implemented.
7. **Improving Medication Safety in Community Pharmacy: Assessing Risk and Opportunities for Change**
   [http://www.ismp.org/communityRx/aroc/](http://www.ismp.org/communityRx/aroc/) (requires email address for access)

   This manual is designed to help community pharmacy personnel identify potential medication safety risks and prevent errors. Pharmacists can use the materials and tools in this manual to pinpoint specific areas of weakness in their medication delivery systems and to provide a starting point for successful organizational improvements.

   The goals of this manual are to:
   - Raise awareness of error-prone processes in the medication delivery system.
   - Build awareness of risk-identification opportunities in the community pharmacy setting.
   - Maximize the appropriate application of system strategies to reduce organizational risk.

8. **Institute for Healthcare Improvement: Plan-Do-Study-Act (PDSA) Worksheet**
   [http://www.ihi.org/resources/Pages/Tools/PlanDoStudyActWorksheet.aspx](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), carrying out the test (Do), observing and learning from the results (Study), and determining needed modifications (Act).

9. **Institute for Healthcare Improvement: Tools**
   [http://www.ihi.org/resources/Pages/Tools/default.aspx](http://www.ihi.org/resources/Pages/Tools/default.aspx)

   The IHI Web site features tools to help organizations accelerate improvement. Users can search for tools related to particular topics using the “My Filters” button. For example, pharmacies might be interested in filtering results by pharmacist in the role/profession field or by medication safety in topics.

10. **Mistake Proofing the Design of Health Care Processes**

    This resource is a synthesis of practical examples from the real 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, in many cases relatively inexpensively. By using this resource, risk managers and chief medical officers can benefit from commonsense approaches to reducing risk and litigation. In addition, organizations can find the groundwork for a successful program that fosters innovation and creativity as they address their patient safety concerns and approaches.
11. **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.

12. **Will It Work Here?: A Decisionmaker’s Guide to Adopting Innovations**

The goal of this guide is to promote evidence-based decisionmaking and help decisionmakers determine whether an innovation would be a good fit or an appropriate stretch for their health care organization.

Cross-reference to resources already described:

- Dimension 9. Response to Mistakes, #2 [Decision Tree for Unsafe Acts Culpability](#).
- Dimension 1. Physical Space and Environment, #3 [Using Change Concepts for Improvement](#).

**Dimension 11. Overall Perceptions of Patient Safety**

1. **Basic Patient Safety Program Resource Guide for “Getting Started”**

This resource guide has tools to help health care facilities implement a patient safety program. The program tools, all of which may be customized as needed, include:

- 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 information on unanticipated outcomes
- Checklist for patient safety and The Joint Commission on the Accreditation of Healthcare Organizations standards

2. **Making Health Care Safer II: An Updated Critical Analysis of the Evidence for Patient Safety Practices**
http://www.ahrq.gov/research/findings/evidence-based-reports/ptsafetyuptp.html

This AHRQ evidence report updates the 2001 report *Making Health Care Safer: A Critical Analysis of Patient Safety Practices*. The goal of this project was to review important patient safety practices for evidence of effectiveness, implementation, and adoption. For example, it discusses the use of clinical pharmacists to prevent adverse drug events.
3. **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.

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

This toolkit provides health care leaders and frontline staff with 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.

Cross-reference to resources already described:

- **Dimension 1. Physical Space and Environment, #2 Institute for Safe Medication Practices (ISMP) Medication Safety Self Assessment® for Community/Ambulatory Pharmacy**