Improving Patient Safety in Hospitals: A Resource List for Users of the AHRQ Hospital Survey on Patient Safety Culture

Purpose

This document contains references to Web sites that provide practical resources hospitals 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 hospitals 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) Hospital Survey on Patient Safety Culture (Available at: http://www.ahrq.gov/professionals/quality-patient-safety/patientsafetyculture/hospital/index.html).

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.

Prepared by
Westat under contract number HHSA 290201300003C for the Agency for Healthcare Research and Quality
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1. 10 Patient Safety Tips for Hospitals

Medical errors (or adverse events) can occur at many points in the health care system, particularly in hospitals. These tips for hospitals are from studies by the Agency for Healthcare Research and Quality, which has funded more than 100 patient safety projects since 2001. Hospitals can put many findings from AHRQ research into practice by following these 10 practical tips.

2. 10 Tips to Help Promote Patient Safety

This fact sheet lists 10 patient safety concerns and offers tips to address them.

3. 2011 ISMP Medication Safety Self Assessment® for Hospitals

The 2011 ISMP Medication Safety Self-Assessment® for Hospitals is designed to:

- Heighten awareness of distinguishing characteristics of a safe hospital medication system.
- Create a new baseline in 2011 of hospital efforts to enhance medication safety.
- Evaluate our Nation’s progress in medication safety over the last decade.

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.
5. **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. It also addresses six priority areas for quality improvement, as identified in the *National Strategy for Quality Improvement in Health Care*.

6. **2014 National Patient Safety Goals Critical Access Hospital Program**  
http://www.jointcommission.org/standards_information/npsgs.aspx

The purpose of the Joint Commission National Patient Safety Goals Critical Access Hospital Program is to improve patient safety in critical access hospitals 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, it has information regarding the new numbering system and minor language changes for consistency.

7. **2014 National Patient Safety Goals Hospital Program**  
http://www.jointcommission.org/standards_information/npsgs.aspx

The purpose of the Joint Commission National Patient Safety Goals Hospital Program is to improve patient safety in hospitals 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, it has information regarding the new numbering system and minor language changes for consistency.

8. **30 Safe Practices for Better Health Care Fact Sheet**  

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.
9. **AHRQ Health Care Innovations Exchange**  

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.

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

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

The Agency for Healthcare Research and Quality’s Medical Errors and Patient Safety Web page provides links to various fact sheets, including information on how to improve health care quality and reduce and prevent adverse drug events, as well as patient safety research highlights and other related topics.

11. **AHRQ Patient Safety Education and Training Catalogue**  

The Agency for Healthcare Research and Quality’s Patient Safety Education and Training Catalog consists of numerous patient safety programs currently available in the United States. The catalog, which is featured on AHRQ’s Patient Safety Network, 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.
12. AHRQ Patient Safety Network  
http://www.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.

13. 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

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

This tool was developed by the Picker Institute, Inc. It 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.

15. Ask Suicide-Screening Questions  

This screening tool from the National Institute of Mental Health, called the Ask Suicide-Screening Questions (ASQ), is a set of four questions that emergency department nurses or physicians can administer to help identify youth at risk for attempting suicide.
16. Becoming a High Reliability Organization

This Agency for Healthcare Research and Quality document is written for hospital leaders interested in providing patients safer and higher quality care. It presents the thoughts, successes, and failures of hospital leaders who have used concepts of high reliability to make patient care better. High reliability concepts are tools that a growing number of hospitals use to help achieve their safety, quality, and efficiency goals. Creating a culture and processes that radically reduce system failures and effectively respond when failures do occur is the goal of high reliability thinking.

17. CAHPS® Hospital Survey

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) program is a multiyear Agency for Healthcare Research and Quality initiative to support the assessment of consumers’ experiences with health care. This Web site provides information on the CAHPS® Hospital Survey (H-CAHPS®), including the questionnaire and administration guidelines, as well as reporting and benchmarking data.

18. 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.

19. 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.
20. The Commonwealth Fund
http://www.commonwealthfund.org/

The Commonwealth Fund is a private foundation that promotes 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.

21. Consumers Advancing Patient Safety
http://www.consumersadvancingpatientsafety.org/caps/

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. 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.

23. Coordinated-Transitional Care Toolkit
http://www.hipxchange.org/C-trac (requires login)

This tool was developed by the University of Wisconsin-Madison School of Medicine & Public Health and the William S Middleton Memorial Veterans Hospital. 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
24. Department of Defense Patient Safety Program

The Department of Defense Patient Safety Program is a comprehensive program with the goal of establishing 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. Department of Veterans Affairs National Center for Patient Safety
http://www.patientsafety.va.gov

The National Center for Patient Safety (NCPS) 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.

26. Department of Veterans 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.

27. Guide for Developing a Community-Based Patient Safety Advisory Council

The Guide for Developing a Community-Based Patient Safety Advisory Council provides information and guidance to empower individuals and organizations to develop a community-based advisory council. These councils involve patients, consumers, and a variety of practitioners and professionals from health care and community organizations to drive change for patient safety through education, collaboration, and consumer engagement.

28. Guide to Patient and Family Engagement in Hospital Quality and Safety

This toolkit published by the Agency for Healthcare Research and Quality is designed to help hospitals develop partnerships with patients and families to improve quality and safety. Developed with input from clinicians and patients, the guide emphasizes four strategies—working with patients and families as advisors, communicating to improve quality, integrating patients and families into shift changes, and using patient input to improve the discharge process.
29. Health Research & Educational Trust (HRET) Disparities Toolkit
http://www.hretdisparities.org/

The Health Research & Educational Trust (HRET) Disparities Toolkit provides resources and information to help hospitals collect demographic information from patients, such as race, ethnicity, and primary language data.

30. Improvement Capability Self-Assessment Tool
http://www.ihi.org/resources/Pages/Tools/IHIImprovementCapabilitySelfAssessmentTool.aspx

The Improvement Capability Self-Assessment Tool from the Institute for Healthcare Improvement 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/Pages/default.aspx

The Institute for Healthcare Improvement (IHI) 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 (ISMP) offers a wide variety of free educational materials and services on their Web site, which include:

- 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. 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.

34. Medically Induced Trauma Support Services (MITSS)
http://www.mitss.org/index.html

Medically Induced Trauma Support Services (MITSS) is a nonprofit organization whose mission is “to support healing and restore hope” to patients, families, and clinicians who have been affected by an adverse medical event. MITSS achieves its mission by:

- Creating awareness and providing education.
- Providing direct support services to patients, families, and clinicians.
- Advocating for action.

Tools developed to support the MITSS mission are available at: http://www.mitsstools.org/.

35. Minnesota Alliance for Patient Safety
http://www.mnpatientsafety.org

The Minnesota Alliance for Patient Safety (MAPS) is a partnership among the Minnesota Hospital Association, Minnesota Medical Association, Minnesota Department of Health, and more than 50 other public-private health care organizations working together to improve patient safety.

36. National Committee for Quality Assurance
http://www.ncqa.org/

The National Committee for Quality Assurance (NCQA) is a private, not-for-profit organization dedicated to improving health care quality. NCQA develops quality standards and performance measures for a broad range of health care entities. These measures and standards are the tools that organizations and individuals can use to identify opportunities for improvement. The annual reporting of performance against such measures has become a focal point for the media, consumers, and health plans, which use these results to set their improvement agendas for the following year.
37. 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.

38. National Quality Forum
http://www.qualityforum.org/Topics/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.


Comprehension during surgical informed consent is an important part of patient safety in the hospital environment. A good resource for strategies as to how to implement this Safe Practice within your organization is a User’s Guide developed by the National Quality Forum.

40. Partnering To Heal: Teaming Up Against Healthcare-Associated Infections
http://www.health.gov/hai/training.asp

This training program from the U.S. Department of Health and Human Services explores how to create a culture of safety and prevent healthcare-associated infections.

41. Partnering With Patients to Create Safe Care
http://webmedia.unmc.edu/nursing/grants/jcuddiga/ihi2008/media/sIH08136.htm

Partnering with Patients to Create Safe Care is a presentation from the Institute for Healthcare Improvement National Forum by representatives at the Dana-Farber Cancer Institute. The presentation highlights Dana-Farber’s journey in family-centered care and the steps needed to advance patient and family participation in safety and quality initiatives.
42. 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.

43. The Patient Education Materials Assessment Tool (PEMAT) and User’s Guide  

The Patient Education Materials Assessment Tool (PEMAT) is a systematic method to evaluate and compare the understandability and actionability of patient education materials. It is designed as a guide to help determine whether patients will be able to understand and act on information. Separate tools are available for use with print and audiovisual materials.

44. Patient Safety in Small Rural Hospitals  
http://www.unmc.edu/patient-safety/surveys.htm

Under the leadership of Dr. Katherine Jones, the University of Nebraska Medical Center has conducted and interpreted the AHRQ Survey on Patient Safety Culture for over 100 small rural hospitals located in 15 states. This Web site provides a variety of patient safety tools that can be used with the survey, as well as adaptations that have been used by the UNMC team.

45. Patient Safety Primer: Medication Errors  

A growing evidence base supports specific strategies to prevent adverse drug events (ADEs). The Agency for Healthcare Research and Quality’s 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.
46. 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, adverse drug reaction), discipline, audience, and patient safety focus.

47. Premier Safety Institute®

The Premier Safety Institute® provides safety resources and tools to promote a safe health care delivery environment for patients, workers, and their communities.

48. Preventing Falls in Hospitals: A Toolkit for Improving Quality of Care

Preventing Falls in Hospitals: A Toolkit for Improving Quality of Care can help hospitals reduce falls that occur during a patient’s hospital stay. The toolkit addresses hospital readiness, program management, choosing fall prevention practices, implementation, measurement, and sustainability.

49. Preventing Hospital-Acquired Venous Thromboembolism: A Guide for Effective Quality Improvement

Pulmonary embolism resulting from deep vein thrombosis—collectively referred to as venous thromboembolism—is the most common preventable cause of hospital death. Pharmacologic methods to prevent venous thromboembolism are safe, effective, cost-effective, and advocated by authoritative guidelines, yet large prospective studies continue to demonstrate that these preventive methods are significantly underused. Based on quality improvement initiatives undertaken at the University of California, San Diego Medical Center and Emory University Hospitals, this guide from the Agency for Healthcare Research and Quality assists quality improvement practitioners in leading an effort to improve prevention of one of the most important problems facing hospitalized patients, hospital-acquired venous thromboembolism.
50. Preventing Pressure Ulcers in Hospitals: A Toolkit for Improving Quality of Care

Each year, more than 2.5 million people in the United States develop pressure ulcers. These skin lesions bring pain, associated risk for serious infection, and increased health care utilization. The aim of this toolkit from the Agency for Healthcare Research and Quality is to assist hospital staff in implementing effective pressure ulcer prevention practices through an interdisciplinary approach to care.

51. 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.

52. 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 the following:

- High Priority Practices
- Organizational Responsibilities
- Patient Identification
- Computerized Physician Order Entry (CPOE) With Decision Support
- Test Results Review and Followup
- Clinician Communication
- Contingency Planning
- System Interfaces
- System Configuration
53. Safety Is Personal: Partnering With Patients and Families for the Safest Care  

This report from the National Patient Safety Foundation’s Lucian Leape Institute is a call to action for health leaders, clinicians, and policymakers to take the necessary steps to ensure patient and family engagement at all levels of health care. It identifies specific action items for health leaders, clinicians, and policymakers to pursue in making patient and family engagement a core value in the provision of health care.

54. Society to Improve Diagnosis in Medicine  
<http://www.improvediagnosis.org/>

As patients, clinicians, researchers, educators, insurers, and health care professionals, we seek to understand the nature, causes, and remedies for diagnostic errors. Our ultimate goal is to reduce misdiagnosis-related harm and ensure that diagnosis is timely, accurate, reliable, efficient, and safe.

55. Transforming Hospitals: Designing for Safety and Quality  

This DVD reviews the case for evidence-based hospital design and describes how it increases patient and staff satisfaction and safety, quality of care, and employee retention, which results in a positive return on investment.

56. Urgent Matters Toolkit  
<http://smhs.gwu.edu/urgentmatters/toolkit>

The Urgent Matters Toolkit is a collection of strategies and tools designed to target specific issues facing hospital emergency departments. This toolkit was developed by hospitals across the country in conjunction with the Urgent Matters national program office at The George Washington University. The Urgent Matters team identified the most innovative patient flow quality improvement strategies implemented by participating pilot hospitals and developed this unique Web-based toolkit capturing the strategies designed for hospital use in an easy-to-read and implement format.

57. WHO Patient Safety – Implementing Change  
<http://www.who.int/patientsafety/implementation/en/>

World Health Organization (WHO) Patient Safety works to ensure that patient safety measures and solutions can be implemented in a variety of health care settings worldwide. Their work on implementation ranges from providing guidelines for national and subnational patient safety reporting and learning systems to solutions to common patient safety issues.
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.

Resources by Dimension

The following resources are organized according to the relevant Hospital 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. Teamwork within Units

1. AHRQ Comprehensive Unit-based Safety Program (CUSP)
http://www.ahrq.gov/professionals/education/curriculum-tools/cusptoolkit/

The Comprehensive Unit-based Safety Program (CUSP) toolkit includes training tools to make care safer by improving the foundation of how your physicians, nurses, and other clinical team members work together. It builds the capacity to address safety issues by combining clinical best practices and the science of safety.

2. Crisis Management Simulation Course Receives Positive Reviews, Enhances Communication and Teamwork Among Labor and Delivery Practitioners During Crises
http://www.innovations.ahrq.gov/content.aspx?id=265

This featured profile is available on the Agency for Healthcare Research and Quality’s Health Care Innovations Exchange Web site. Crisis Resource Management (CRM) is a 7-hour course for labor and delivery (L&D) practitioners. It uses various strategies of crew resource management, a safety program developed by the aviation industry, to create realistic simulations designed to facilitate improvement of teamwork and communication skills in a real L&D crisis. According to postimplementation surveys, the course is highly regarded by the vast majority of participants. Surveys conducted 1 or more years after the course suggest that it produces lasting benefits, including improvements in communication, team leadership, and team performance during crises.

3. Curricula for Simulated Obstetric Emergency Response Drills & Safety (CORDS™)
http://www.obsafety.org/content/blogcategory/53/101/

The CORDS™ toolkit was designed to use military and aviation style simulation experiences to prepare labor and delivery staff for an obstetric emergency. The toolkit also includes information about the importance of communication and teamwork.
   http://www.ahrq.gov/professionals/systems/hospital/esi/esi1.html

The 2012 edition of the *Emergency Severity Index Implementation Handbook* provides the necessary background and information for establishing ESI—a five-level emergency department triage algorithm that provides clinically relevant stratification of patients into five groups from least to most urgent based on patient acuity and resource needs. This edition includes updates throughout plus a new section on using the ESI algorithm with pediatric populations. The Agency for Healthcare Research and Quality funded initial work on the ESI.

5. **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 Agency for Healthcare Research and Quality’s Patient Safety Network explains this topic further and provides links for more information on what is new in teamwork training.

6. **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

7. **Pennsylvania Patient Safety Advisory (Vol.7, Suppl. 2)**
   http://www.patientsafetyauthority.org/ADVISORIES/AdvisoryLibrary/2010/jun16_7(suppl2)/Documents/jun16;7(suppl2).pdf

This supplement from the Pennsylvania Patient Safety Authority outlines tactics to improve communication, including crew resource management, chain-of-command policies, and teamwork training.
8. **TeamSTEPPS® — Team Strategies and Tools to Enhance Performance and Patient Safety**
http://teamstepps.ahrq.gov/

Developed jointly by the Department of Defense (DoD) and the Agency for Healthcare Research and Quality, 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.

9. **TeamSTEPPS® Enhancing Safety for Patients With Limited English Proficiency Module**

The TeamSTEPPS® Limited English Proficiency module is designed to help you develop and deploy a customized plan to train your staff in teamwork skills specific to patients with limited English proficiency and lead a medical teamwork improvement initiative in your organization from initial concept development through to sustainment of positive changes.

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

This evidence-based module will provide 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.

11. **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 responses or to answer the questions with a larger group (e.g., senior leaders).
**Dimension 2. Supervisor/Manager Expectations and Actions**

**Promoting Patient Safety and**

**Dimension 3. Management Support for Patient Safety**

1. **Appoint a Safety Champion for Every Unit**
   [http://www.ihi.org/resources/Pages/Changes/AppointaSafetyChampionforEveryUnit.aspx](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](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 own organization by making regular rounds to discuss safety issues with the frontline staff. This Institute for Healthcare Improvement Web site discusses the benefits of 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. **Get Boards on Board**
   [http://www.ihi.org/resources/Pages/Publications/GettingBoardsonBoard.aspx](http://www.ihi.org/resources/Pages/Publications/GettingBoardsonBoard.aspx)

   This resource from the Institute for Healthcare Improvement offers a how-to guide, presentation, tools, and resources for obtaining board support for patient safety.

4. **Institute for Healthcare Improvement Framework for Leadership for Improvement**
   [http://www.ihi.org/resources/Pages/Tools/IHIFrameworkforLeadershipforImprovement.aspx](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.

5. **Leadership Guide to Patient Safety**

   This guide is part of the Innovation series from the Institute for Healthcare Improvement. It shares the experience of senior leaders who have decided to address patient safety and quality as a strategic imperative within their organizations. It presents what can be done to make the dramatic changes that are needed to ensure that patients are not harmed by the care systems they trust will heal them.
6. Patient Safety Initiative: Hospital Executive and Physician Leadership Strategies

Effectiveness of executive and physician leadership is essential to hospitals’ successful implementation and sustainment of safe practices. This 39-page toolkit, developed by the Joint Commission Resources (JCR) Hospital Engagement Network (HEN) team, as part of the national Partnership for Patients initiative (PfP), includes a concise synopsis of activities that help leaders and medical staff members activate their support for patient safety.

7. 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.

8. Strategies for Leadership: Patient- and Family-Centered Care
http://www.aha.org/advocacy-issues/quality/strategies-patientcentered.shtml

This “Strategies for Leadership” toolkit from the American Hospital Association (AHA) complements previous toolkits and other AHA activities that have focused on safety, effectiveness, efficiency, timeliness, and equity in care. It features a video, discussion guide, and resource guide.

**Dimension 4. Organizational Learning — Continuous Improvement**

1. Adopting “Flow Management” Improves Efficiency, Throughput, and Quality of Care in Hospital Surgery Units
http://innovations.ahrq.gov/content.aspx?id=1714

Borrowing from other industries, St. John’s Regional Health Center implemented principles of “flow management” to redesign the flow of operations in its medical–surgical department. The program increased the department’s capacity to serve patients (by reducing delayed and canceled surgeries), enhanced quality of care and patient and provider satisfaction, and reduced overtime costs and surgeon downtime. This program is featured on the Agency for Healthcare Research and Quality’s Health Care Innovations Exchange Web site.

2. AHRQ Health Care Innovations Exchange: Learn & Network
http://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.
3. **AHRQ Quality Indicators™ Toolkit for Hospitals**

The Agency for Healthcare Research and Quality’s Quality Indicators (QIs) are measures of hospital quality and safety drawn from readily available hospital inpatient administrative data. Hospitals across the country are using QIs to identify potential concerns about quality and safety and track their performance over time. This toolkit supports hospitals that want to improve performance on the Inpatient QIs and Patient Safety Indicators by guiding them through the process, from the first stage of self-assessment to the final stage of ongoing monitoring. The tools are practical, easy to use, and designed to meet a variety of needs, including those of senior leaders, quality staff, and multistakeholder improvement teams.

4. **Common Cause Analysis: A Hospital’s Review of Vulnerabilities During Which Common Themes Are Identified, Prioritized, and Addressed**

Root cause analysis is widely used to identify the underlying causes of medical errors. Exclusive reliance on root cause analyses, however, can result in a lengthy list of action items (too many to be addressed) and the failure to get an accurate view of the “big picture”—common themes and issues affecting safety. A children’s hospital annually reviews all findings from root cause analysis to identify and address common themes and vulnerabilities, leading to a number of institutionwide changes that have improved patient safety and to better communication about safety issues with organizational leaders. This program is featured on the Agency for Healthcare Research and Quality’s Health Care Innovations Exchange Web site.

5. **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. Staff can use this decision tree when analyzing an error or adverse event 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 in an organization.

6. **Department of Veterans Affairs National Center for Patient Safety – Root Cause Analysis**

The National Center for Patient Safety uses a multidisciplinary team approach, known as Root Cause Analysis (RCA) to study healthcare-related adverse events and close calls. The goal of the RCA process is to find out what happened, why it happened, and how to prevent it from happening again. Because the Center’s Culture of Safety is based on prevention, not punishment, RCA teams investigate how well patient care systems function. The focus is on the “how” and the “why,” not on the “who.” Through the application of Human Factors Engineering (HFE) approaches, the National Center for Patient Safety aims to support human performance.
7. Institute for Healthcare Improvement Plan-Do-Study-Act (PDSA) Worksheet
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).

http://www.ahrq.gov/research/findings/final-reports/ptflow/index.html

This guide from the Agency for Healthcare Research and Quality presents step-by-step instructions that can be used by hospitals in planning and implementing patient flow improvement strategies to ease emergency department crowding.

9. Mistake-Proofing the Design of Health Care Processes

This resource 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, in many cases relatively inexpensively. By using this resource, risk managers and chief medical officers can benefit from common-sense 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.

10. 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.
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 Agency for Healthcare Research and Quality’s Patient Safety Network explains this topic further and provides links for more information on what is new in RCA.

12. 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.

13. 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.

14. Voluntary System to Report and Analyze Nursing Errors Leads to Patient Safety Improvements
http://www.innovations.ahrq.gov/content.aspx?id=2246

This featured profile is available on the Agency for Healthcare Research and Quality’s Health Care Innovations Exchange Web site. The Healthcare Alliance Safety Partnership is a 3-year quality improvement pilot project involving a board of nursing and three hospital systems. They are developing a voluntary, nonpunitive system for reporting, investigating, and analyzing nursing errors. During the 3 years of reporting, nurses reported incidents to the partnership. Then, nurse analysts performed an extensive investigation and worked with a multidisciplinary committee to make prescriptive recommendations to the nurse and the institution. These recommendations covered organizational, individual, and technical improvements that could be made to reduce the chance of recurrence. Although the number of participating nurses was limited, the changes the hospital systems made helped to address a wide variety of safety problems that were directly under the control of these organizations and led to the adoption of many quality improvements.

15. 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.
**Dimension 5. Overall Perceptions of Patient Safety**

1. **Basic Patient Safety Program Resource Guide for “Getting Started”**
   
   
   This resource guide provides tools to assist health care facilities implement a patient safety program. It 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
   - A sample grid for listing committee assignments to document and demonstrate the interdisciplinary aspects of the organization’s safety program
   - A document shared by the American Society of Healthcare Risk Management that may be helpful for developing a process for disclosing medical errors to patients and family
   - Checklist for patient safety and Joint Commission on the Accreditation of Healthcare Organizations standards

2. **Central Line Insertion Checklist**
   
   http://www.ihi.org/resources/Pages/Tools/CentralLineInsertionChecklist.aspx
   
   This checklist is used to document activities that are considered standard practice in a critical care unit before, during, and after a central line procedure. It helps to ensure that all processes related to central line placement are executed for each line placement, thereby leading to a reliable process.

3. **Color-Coded Wristband Standardization in Arizona Implementation Toolkit**
   
   http://static.squarespace.com/static/52a62872e4b0cfb0c7cce4b2/t/52acf0a8e4b0cfa18156df35/1387065512472
   
   This toolkit can help hospitals implement a standardized color-coded wristband system, using Arizona’s model. In 2006, Arizona hospitals began a Statewide initiative to use color-coded wristbands to help hospital workers identify at-risk patients, including those who have do-not-resuscitate (DNR) orders, have allergies, or are at risk for falls. Since many health care workers practice at more than one hospital, standardized wristband colors help them avoid confusion and possible medical error.
4. Healthcare Provider Toolkit
http://www.oneandonlycampaign.org/content/healthcare-provider-toolkit

This toolkit will assist individuals and organizations with educating health care providers and patients about safe injection practices. Any health care provider who 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.

5. How-To Guide: Improving Hand Hygiene
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.
- Ways to begin improving hand hygiene compliance in your organization, including establishing a team, setting aims, testing changes, and measuring results.
- Measurement support tools.

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.

7. Patient Safety Primer: Checklists

Most errors in health care are defined as slips rather than mistakes, and checklists can help prevent them, according to a patient safety primer available from the Agency for Healthcare Research and Quality’s Patient Safety Network. The primer explains how participants in a project in Michigan successfully reduced central line-associated bloodstream infections by employing checklists along with extensive preparatory work in safety culture and teamwork. While checklists can be used effectively to reduce the risk of errors where standardizing behavior is the goal, the primer notes that they are not appropriate for every problem. Diagnostic errors, for example, require different approaches.

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 Agency for Healthcare Research and Quality’s Patient Safety Network explains this topic further and provides links for more information on what is new in safety culture.

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

This is a checklist of practices known to promote safer care and reduce the risk of adverse events. Hospitals can use this tool to evaluate whether they have safe practices in place and to determine which safe practices they may need to implement or expand. This tool was designed by Steven Meisel, Pharm.D., at Fairview Health Services using information from a report published by the Agency for Healthcare Research and Quality.

10. Protocol for the Prescription of Controlled Substances by Emergency Department Providers
http://rx.lchcare.org/

The Protocol for the Prescription of Controlled Substances by Emergency Department Providers is a one-page, easy-to-understand protocol that can help physicians and nurses decide how to treat patients complaining about pain who may be abusing opioid medications or other controlled substances. The protocol recommends that physicians make a comprehensive effort to verify the patient’s recent medication history, decline (except in rare cases) to refill prescriptions for controlled substances that have allegedly been lost or stolen, and avoid new prescriptions of controlled substances to patients with a history of chronically taking such medications.


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.
12. Toolkit for Reduction of *Clostridium difficile* Infections Through Antimicrobial Stewardship


Prescribing and using antibiotics appropriately can help reduce the development of antibiotic resistance and prevent infections such as *Clostridium difficile* (*C. difficile*). To help hospitals do this, the Agency for Healthcare Research and Quality developed the Toolkit for Reduction of *Clostridium difficile* Infections Through Antimicrobial Stewardship, a step-by-step guide to implementing an antimicrobial stewardship program specifically targeting *C. difficile* infections.


These tools from the Agency for Healthcare Research and Quality will help your unit implement evidence-based practices and eliminate central line-associated blood stream infections (CLABSI). When used with the CUSP (Comprehensive Unit-based Safety Program) Toolkit, these tools dramatically reduced CLABSI rates in more than 1,000 hospitals across the country.

14. The Transforming Care at the Bedside Toolkit


This toolkit provides information for hospital units interested in adopting the Transforming Care at the Bedside (TCAB) model of nurse-initiated quality improvements. TCAB is a national program developed and managed by the Robert Wood Johnson Foundation and the Institute for Healthcare Improvement.

**Dimension 6. Feedback and Communication About Error**

1. Conduct Safety Briefings

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 Front-Line Staff

http://www.ihi.org/resources/Pages/Changes/ProvideFeedbacktoFrontLineStaff.aspx

Feedback to the front-line 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 page identifies tips and tools for how to communicate 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.

**Dimension 7. Communication Openness**

1. Rapid Response Team Record With SBAR
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

- 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.

3. SBAR Training Scenarios and Competency Assessment
http://www.ihi.org/resources/Pages/Tools/SBARTrainingScenariosandCompetencyAssessment.aspx

These SBAR training scenarios reflect a range of clinical conditions and patient circumstances and are used in conjunction with other SBAR training materials to assess frontline staff competency in using the SBAR technique for communication.
4. Surveys: Nurse and Physician Attitudes about Communication and Collaboration
http://www.ihi.org/resources/Pages/Tools/SurveysNursePhysicianAttitudesCommunicationCollaboration.aspx

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-references to resources already described:

- Dimension 1. Teamwork within Units, #2 Crisis Management Simulation Course
- Dimension 1. Teamwork within Units, #3 Curricula for Simulated Obstetric Emergency Response Drills & Safety (CORDS™)
- Dimension 1. Teamwork within Units, #6 Patient Safety Through Teamwork and Communication Toolkit
- Dimension 1. Teamwork within Units, #7 Pennsylvania Patient Safety Advisory

**Dimension 8. Frequency of Events Reported**

1. Multifaceted Program Increases Reporting of Potential Errors, Leads to Action Plans To Enhance Safety

This featured profile is available on the Agency for Healthcare Research and Quality’s Health Care Innovations Exchange Web site. The University of Texas M.D. Anderson Cancer Center implemented a multifaceted initiative, known as the Good Catch Program. The program was designed to increase the reporting of potential errors related to medication, equipment, and patient care. Key elements of the program include (1) a change in use of terminology from negative to positive terms and phrases (e.g., from “close call” or “near miss” to “good catch”); (2) friendly, team-based competition to promote reporting; (3) development of an end-of-shift safety report; (4) executive leadership-sponsored rounds and incentives; and (5) a multidisciplinary workgroup to promote reporting. The program increased the reporting of potential errors dramatically, by 1,468 percent, in the 6-month pilot phase of the program and spurred the development of action plans designed to address the common causes of potential errors.

2. Patient Safety Toolbox for States
http://www.nashp.org/pst-welcome

This electronic toolbox is intended to provide States with tools they can use or modify as they develop or improve adverse event reporting systems. The toolbox includes information (policies, practices, forms, reports, methods, and contracts) related to State reporting systems, links to other Web resources, and fast facts and issues related to patient safety.
**Dimension 9. Teamwork Across Units**

Cross-references to resources already described:

- Dimension 1. Teamwork within Units, #5 Patient Safety Primer: Teamwork Training
- Dimension 1. Teamwork within Units, #6 Patient Safety through Teamwork and Communication Toolkit
- Dimension 1. Teamwork within Units, #7 Pennsylvania Patient Safety Advisory
- Dimension 1. Teamwork within Units, #8 TeamSTEPPS®—Team Strategies and Tools to Enhance Performance and Patient Safety

**Dimension 10. Staffing**

1. **Hospital Nurse Staffing and Quality of Care**

   This report summarizes the findings of Agency for Healthcare Research and Quality-funded projects and other research on the relationship of nurse staffing levels to adverse patient outcomes. This information can be used by decision makers to make more informed choices in terms of adjusting nurse staffing levels and increasing nurse recruitment while optimizing quality of care and improving nurse satisfaction.

2. **Resident Duty Hours: Enhancing Sleep, Supervision, and Safety**
   [http://www.iom.edu/~media/Files/Report%20Files/2008/Resident-Duty-Hours/residency%20hours%20revised%20for%20web.ashx](http://www.iom.edu/~media/Files/Report%20Files/2008/Resident-Duty-Hours/residency%20hours%20revised%20for%20web.ashx)

   This December 2008 report brief for an Agency for Healthcare Research and Quality-funded study from the Institute of Medicine (IOM) confirms that acute and chronically fatigued medical residents are more likely to make mistakes that affect patient care. The IOM recommends several changes to the existing limit on resident work hours of 80 hours per week. For example, the IOM recommends that residency programs provide opportunities for sleep each day and each week during resident training, the Accreditation Council for Graduate Medical Education provide better monitoring of duty hour limits, and residency review committees set guidelines for residents’ patient caseloads.
Dimension 11. Handoffs and Transitions

1. **BOOST Implementation Toolkit**

   The Project BOOST (Better Outcomes by Optimizing Safe Transitions) Implementation Toolkit provides a wealth of materials to help hospitals optimize the discharge process. These tools can help to:
   
   - Analyze current workflow processes.
   - Select effective interventions.
   - Redesign workflow and implement interventions.
   - Educate your team on best practices.
   - Promote a team approach to safe and effective discharges.
   - Evaluate your progress and modify your interventions accordingly.

2. **Discharge Knowledge Assessment Tool (DKAT)**

   This worksheet can help hospital staff perform a structured assessment of patient knowledge prior to discharge from the hospital by evaluating patients’ knowledge about their medical condition and followup care. The intervention improves the safety of patient discharges from the hospital by increasing patients’ understanding of their illness and treatment and fostering continuity of care.

3. **Door-to-Doc Patient Safety Toolkit**

   Door-to-Doc is a patient flow redesign process that improves the safety of care for patients in the emergency department by reducing the time patients wait to be seen and by expediting admission to the most appropriate hospital unit.

4. **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 patient, Diagnosis, recent Events, Anticipated changes, Leave time for questions).
5. Handoffs and Signouts

The process of transferring responsibility for care is referred to as the handoff, with the term signout used to refer to the act of transmitting information about the patient. The Agency for Healthcare Research and Quality’s Patient Safety Network explains this topic further and provides links for more information on what is new in handoffs and signouts in the context of care during hospitalization.

6. Handoffs and Transition in the Emergency Department Setting

In order to provide collaborative teams with an opportunity to learn from their faculty and other collaborative teams, the Maryland Patient Safety Center hosted a call in September 2006 to discuss strategies that lead to more effective handoffs among staff and units in the hospital. This summary is intended to share this discussion and lessons learned from that call.

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

This How-To Guide describes key evidence-based care components to prevent adverse drug events 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 the Institute for Healthcare Improvement’s 5 Million Lives Campaign.

8. Improving on Transitions of Care: How To Implement and Evaluate a Plan

This guide helps health care institutions develop and implement processes for sending and receiving patients from one care setting to another. The information and plans provided allow institutions to measure their performance in transitions of care and identify areas for improvement.

9. Improving Transitions of Care: Hand-Off Communications

This tool describes factors that contribute to incomplete handoffs and recommends tactics to improve handoff communication.
10. 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 a layer of safety by enabling the patient to communicate potential safety concerns.

11. ISMP’s List of Confused Drug Names

Drawing on information gathered from the ISMP Medication Errors Reporting Program, this fact sheet provides a comprehensive list of commonly confused medication names, including look-alike and sound-alike name pairs. Drug name confusion can easily lead to medication errors, and the ISMP has recommended interventions such as the use of mixed case lettering to prevent such errors.

12. MARQUIS Medication Reconciliation Resource Center
http://www.hospitalmedicine.org/Content/NavigationMenu/QualityImprovement/QIResourceRooms2/MARQUIS/Medication_Reconciliation.htm

Unintentional medication discrepancies during transitions in care (such as hospitalization and subsequent discharge) are very common and represent a major threat to patient safety. In 2010, the Agency for Healthcare Research and Quality awarded the Society of Hospital Medicine (SHM) a $1.5 million grant for a 3-year Multi-Center Medication Reconciliation Quality Improvement Study (MARQUIS). The goal of MARQUIS is to develop better ways for medications to be prescribed, documented, and reconciled accurately and safely at times of care transitions when patients enter and leave the hospital.

13. Medication Reconciliation Flowsheet
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.
14. Medication Reconciliation Review: Data Collection Form
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.

15. 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 the Institute for Healthcare Improvement’s 5 Million Lives Campaign intervention.

16. Medications At Transitions and Clinical Handoffs (MATCH) Initiative
http://www.nmh.org/nm/for-physicians-match

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. It provides a step-by-step guide to improving the medication reconciliation process and includes guidelines, flowcharts, modifiable templates, and lessons learned.

17. Patient Safety Primer: Medication Reconciliation
http://psnet.ahrq.gov/primer.aspx?primerID=1

Medication reconciliation refers to the process of avoiding inadvertent inconsistencies across transitions in care. It involves reviewing the patient’s complete medication regimen at the time of admission, transfer, and discharge and comparing it with the regimen being considered for the new setting of care. The Agency for Healthcare Research and Quality’s Patient Safety Network explains this topic further and provides links for more information on what is new in medication reconciliation.
18. Perioperative Patient “Hand-Off” Toolkit
http://www.aorn.org/PracticeResources/ToolKits/PatientHandOffToolKit/

The Association of periOperative Registered Nurses and the DoD Patient Safety Program collaboratively developed this new Web-based toolkit that provides resources to guide perioperative professionals in standardizing handoff communications among caregivers. The toolkit, based on the TeamSTEPPS initiative, will help develop consistency in communications needed for effective patient care. The toolkit includes supporting research for evidence-based recommendations on perioperative patient handoffs, sample checklists and forms, PowerPoint presentations on standardizing communication and information exchanges in perioperative practice, and an annotated guide to additional resources.

19. Your Discharge Checklist: For Patients and Their Caregivers Preparing To Leave a Hospital, Nursing Home, or Other Care Setting (out of order due to name change)
http://www.medicare.gov/Publications/Pubs/pdf/11376.pdf

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.

20. RED (Re-Engineered Discharge) Toolkit

These tools were developed to facilitate the Project RED (Re-Engineered Hospital Discharge) intervention. Project RED is a randomized controlled trial at Boston Medical Center. This project reengineers the workflow process and improves patient safety for patients from a network of community health centers discharged from a general medical service at an urban hospital serving a low-income, ethnically diverse population. The toolkit includes:

- After Hospital Care Plan (AHCP) sample form
- Training manual
- A description of the computerized workstation and process used to create and print the AHCP
21. “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.

22. Strategies to Improve Handoffs

This tool from the Maryland Patient Safety Center provides an outline of recommended strategies to improve the handoff process in hospitals (i.e., patient transitions in care from one provider to another).

23. Transitioning Newborns From NICU to Home: A Resource Toolkit

This toolkit from the Agency for Healthcare Research and Quality includes resources for hospitals that wish to improve safety when newborns transition home from their neonatal intensive care unit (NICU) by creating a Health Coach Program, tools for coaches, and information for parents and families of newborns who have spent time in the NICU.

24. Transitions of Care Checklist
http://www ntocc.org/Portals/0/PDF/Resources/TOC_Che cklist.pdf

The National Transitions of Care Coalition Advisory Task Force has released a transitions of care list that provides a detailed description of effective patient transfer between practice settings. This process can help to ensure that patients and their critical medical information are transferred in a safe, timely, and efficient manner.

Cross-references to resources already described:

**Dimension 12. Nonpunitive Response to Error**

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. **Leadership Response to a Sentinel Event: Respectful, Effective Crisis Management**
   [http://www.ihi.org/resources/Pages/Tools/LeadershipResponseSentinelEventEffectiveCrisisMgmt.aspx](http://www.ihi.org/resources/Pages/Tools/LeadershipResponseSentinelEventEffectiveCrisisMgmt.aspx)

   This tool was developed by the Institute for Healthcare Improvement. 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](http://www.ihi.org/resources/Pages/Tools/LivingaCultureofPatientSafety.aspx)

   St. John’s Mercy Medical Center created an institutionwide policy regarding nonpunitive reporting, as well as a brochure titled *Living a Culture of Patient Safety* that was developed by its Culture of Safety Subcommittee, signed by the president, and mailed to all coworker homes. The brochure reinforces the nonpunitive reporting policy and encourages all coworkers to report errors.

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

   This presentation from the Agency for Healthcare Research and Quality’s Surveys on Patient Safety Culture User Group Meeting describes Aurora Health Care’s approach to creating of a culture of safety and reviews the action steps taken to address the Nonpunitive Response to Error dimension in the SOPS survey.
5. 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.

6. Patient Safety and the “Just Culture”: A Primer for Health Care Executives  
http://www.safer.healthcare.ucla.edu/safer/archive/ahrq/FinalPrimerDoc.pdf

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 outlines the complex nature of deciding how best to hold individuals accountable for mistakes.

Cross-references to resources already described:

- Dimension 4. Organizational Learning—Continuous Improvement, #5 Decision Tree for Unsafe Acts Culpability
- Dimension 4. Organizational Learning—Continuous Improvement, #14 Voluntary System To Report and Analyze Nursing Errors Leads to Patient Safety Improvements
- Dimension 7. Communication Openness, #2 SBAR Technique for Communication: A Situational Briefing Model
- Dimension 8. Frequency of Events Reported, #1 Multifaceted Program Increases Reporting of Potential Errors, Leads to Action Plans to Enhance Safety