

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

Resources are listed in alphabetical order, organized by the composites 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>), followed by general resources.

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

Updated January 2016

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Alphabetical Index of Resources

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[10 Tips to Help Promote Patient Safety](#)
[2011 ISMP Medication Safety Self Assessment® for Hospitals](#)
[2014 National Healthcare Quality and Disparities Report: Chartbook on Patient Safety](#)
[2015 National Patient Safety Goals Critical Access Hospital Program](#)
[2015 National Patient Safety Goals Hospital Program](#)
[Achieving Efficiency: Lessons from Four Top-Performing Hospitals](#), *NEW*
[AHRO Comprehensive Unit-based Safety Program \(CUSP\)](#)
[AHRO Impact Case Studies](#), *NEW*
[AHRO Patient Safety Education and Training Catalogue](#)
[AHRO Quality Indicators™ Toolkit for Hospitals](#)
[Always Events® Toolbox](#)
[Appoint a Safety Champion for Every Unit](#)
[CAHPS® Improvement Guide](#)
[Call to Action: Safeguarding the Integrity of Healthcare Quality and Safety Systems](#)
[Central Line Insertion Checklist](#)
[Color-coded Wristband Standardization in Arizona Implementation Toolkit](#)
[Common Cause Analysis: A Hospital's Review of Vulnerabilities During Which Common Themes Are Identified, Prioritized, and Addressed](#)
[Conduct Patient Safety Leadership WalkRounds™](#)
[Coordinated-Transitional Care Toolkit](#)
[Crisis Management Simulation Course Receives Positive Reviews, Enhances Communication and Teamwork Among Labor and Delivery Practitioners During Crises](#)
[Decision Tree for Unsafe Acts Culpability](#)
[Department of Defense Patient Safety Program](#)
[Department of Veterans Affairs National Center for Patient Safety –Root Cause Analysis](#)
[Door-to-Doc Patient Safety Toolkit](#)
[Emergency Severity Index \(ESI\): A Triage Tool for Emergency Department Care—Implementation Handbook, 2012 Edition](#)
[Get Boards on Board](#)
[Guide for Developing a Community-Based Patient Safety Advisory Council](#)
[Guide to Patient and Family Engagement in Hospital Quality and Safety](#)
[Hand Hygiene in Healthcare Settings](#), *NEW*
[Healthcare Provider Toolkit](#)
[Hospital Guide to Reducing Medicaid Readmissions](#), *NEW*
[Hospital Inpatient Waste Identification Tool](#), *NEW*
[Hospital Nurse Staffing and Quality of Care](#)
[Implementing Clinical Nurse Leader Role Improves Core Measures Performance, Patient and Physician Satisfaction and Reduces Nurse Turnover](#), *NEW*
[Improvement Capability Self-Assessment Tool](#)
[Improving Patient Flow and Reducing Emergency Department Crowding: A Guide for Hospitals](#)
[I-PASS Handoff Bundle](#), *NEW*
[ISHAPED Patient-Centered Approach to Nurse Shift Change Bedside Report](#)
[ISMP's List of Confused Drug Names](#)
[Leadership Response to a Sentinel Event: Respectful, Effective Crisis Management](#)
[Living a Culture of Patient Safety Policy and Brochure](#)
[MARQUIS \(Multi-Center Medication Reconciliation Quality Improvement Study\) Toolkit](#)
[Medicaid Return on Investment Template](#), *NEW*
[Medically Induced Trauma Support Services \(MITSS\)](#)
[Medication Reconciliation Flowsheet](#)
[Medication Reconciliation Review: Data Collection Form](#)
[Medications At Transitions and Clinical Handoffs \(MATCH\) Toolkit for Medication Reconciliation: Work Plan](#)

[Minnesota Alliance for Patient Safety](#)
[Multifaceted Hospital Program Implemented Over a Decade Leads to Lower Nurse Turnover and Length of Stay, Improved Patient Outcomes, and Enhanced Revenues](#), *NEW*
[Multifaceted Program Increases Reporting of Potential Errors, Leads to Action Plans to Enhance Safety](#)
[Nurse-Led, Unit-Based Quality Improvement Increases Amount of Time Spent With Patients, Reduces Falls and Nurse Turnover](#), *NEW*
[Partnering to Heal: Teaming-Up Against Healthcare-Associated Infections](#)
[Patient- and Family-Centered Care Organizational Self-Assessment Tool](#)
[Patient Safety and the “Just Culture”](#)
[Patient Safety in Small Rural Hospitals](#)
[Patient Safety Initiative: Hospital Executive and Physician Leadership Strategies](#)
[Patient Safety Primer: Checklists](#)
[Patient Safety Primer: Medication Errors](#)
[Patient Safety Primer: Missed Nursing Care](#), *NEW*
[Patient Safety Primer: Safety Culture](#)
[Patient Safety Primer: Teamwork Training](#)
[Patient Safety Primer: Voluntary Patient Safety Event Reporting \(Incident Reporting\)](#), *NEW*
[Patient Safety Self-Assessment Tool](#)
[Patient Safety Toolbox for States](#)
[Patient Safety Workshop – Learning From Error](#), *NEW*
[Pennsylvania Patient Safety Advisory \(Vol. 7, Suppl. 2\)](#)
[Perioperative Patient “Hand-Off” Toolkit](#)
[Plan-Do-Study-Act \(PDSA\) Worksheet](#)
[Premier Safety Institute®](#)
[Provide Feedback to Front-Line Staff](#)
[Quality Improvement Fundamentals Toolkit](#)
[Quality Improvement Savings Tracker Worksheet](#)
[Rapid Response Team Record With SBAR](#)
[RED \(Re-Engineered Discharge\) Toolkit](#)
[Residency Program for First-Year Nurses Eases Entry Into Profession, Producing Well-Above Average Retention Rates](#), *NEW*
[SAFER Guides](#)
[Safety Huddle Results Collection Tool](#)
[“Same Page” Transitional Care Resources for Patients and Care Partners](#)
[SBAR Technique for Communication: A Situational Briefing Model](#)
[SBAR Training Scenarios and Competency Assessment](#)
[State-Mandated Nurse Staffing Levels Alleviate Workloads, Leading to Lower Patient Mortality and Higher Nurse Satisfaction](#), *NEW*
[Strategies for Leadership: Patient- and Family-Centered Care](#)
[Targeted Medication Safety Best Practices for Hospitals](#), *NEW*
[TeamSTEPPS® - Team Strategies and Tools to Enhance Performance and Patient Safety](#)
[TeamSTEPPS® Enhancing Safety for Patients With Limited English Proficiency Module](#)
[TeamSTEPPS® Rapid Response Systems \(RRS\) Training Module](#)
[TeamSTEPPS® Readiness Assessment Tool](#)
[Toolkit for Reduction of *Clostridium difficile* Infections Through Antimicrobial Stewardship](#)
[Tools for Reducing Central Line-Associated Blood Stream Infections](#)
[Transitioning Newborns from NICU to Home: A Resource Toolkit](#)
[Urgent Matters Toolkit](#)
[Using Change Concepts for Improvement](#)
[Voluntary System to Report and Analyze Nursing Errors Leads to Patient Safety Improvements](#)
[Why Not the Best?](#)
[Will It Work Here?: A Decisionmaker’s Guide to Adopting Innovations](#)
[Workforce 2015: Strategy Trumps Shortage](#), *NEW*

Resources by Composite

The following resources are organized according to the relevant Hospital Survey on Patient Safety Culture composites they can help improve. Some resources are duplicated and cross-referenced because they may apply to more than one composite.

Composite 1. Teamwork within Units

1. AHRQ Comprehensive Unit-based Safety Program (CUSP)

<http://www.ahrq.gov/professionals/quality-patient-safety/cusp/index.html>

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

<https://innovations.ahrq.gov/profiles/crisis-management-simulation-course-receives-positive-reviews-enhances-communication-and>

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 post implementation 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. Emergency Severity Index (ESI): A Triage Tool for Emergency Department Care—Implementation Handbook, 2012 Edition

<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.

4. Patient Safety Primer: Teamwork Training

<https://psnet.ahrq.gov/primers/primer/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.

5. Pennsylvania Patient Safety Advisory (Vol.7, Suppl. 2)

[http://www.patientsafetyauthority.org/ADVISORIES/AdvisoryLibrary/2010/jun16_7\(suppl2\)/Documents/jun16;7\(suppl2\).pdf](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.

6. 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.

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

<http://www.ahrq.gov/professionals/education/curriculum-tools/teamstepps/lep/index.html>

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

8. 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.

9. TeamSTEPPS® Readiness Assessment Tool

<http://www.ahrq.gov/professionals/education/curriculum-tools/teamstepps/readiness/index.html>

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).

Composite 2. Supervisor/Manager Expectations and Actions Promoting Patient Safety and Composite 3. Management Support for Patient Safety

1. Appoint a Safety Champion for Every Unit

<http://www.ihi.org/resources/Pages/Changes/AppointaSafetyChampionforEveryUnit.aspx>

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

2. Conduct Patient Safety Leadership WalkRounds™

<http://www.ihi.org/resources/Pages/Changes/ConductPatientSafetyLeadershipWalkRounds.aspx>

Senior leaders can demonstrate their commitment to safety and learn about the safety issues in their 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.

3. Get Boards on Board

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

<http://www.ahrq.gov/professionals/systems/hospital/engagingfamilies/guide.html>

Research shows that when patients are engaged in their health care, it can lead to measurable improvements in safety and quality. To promote stronger engagement, Agency for Healthcare Research and Quality developed the Guide to Patient and Family Engagement in Hospital Quality and Safety, a tested, evidence-based resource to help hospitals work as partners with patients and families to improve quality and safety.

5. Patient Safety Initiative: Hospital Executive and Physician Leadership Strategies
<http://store.jcrinc.com/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 concise synopsis of activities that help leaders and medical staff members activate their support for patient safety.

6. 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.

Composite 4. Organizational Learning — Continuous Improvement

1. AHRQ Patient Safety Education and Training Catalogue
<http://psnet.ahrq.gov/pset>

The Agency for Healthcare Research and Quality's Patient Safety Education and Training Catalog consists of 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.

2. AHRQ Quality Indicators™ Toolkit for Hospitals
<http://www.ahrq.gov/professionals/systems/hospital/qitoolkit/index.html>

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 IQIs and PSIs 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 multi stakeholder improvement teams.

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

<https://innovations.ahrq.gov/profiles/common-cause-analysis-hospitals-review-vulnerabilities-during-which-common-themes-are>

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 analyses to identify and address common themes and vulnerabilities, leading to a number of institution-wide changes that have improved patient safety and 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.

4. 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 systems issues contributed to the event. This decision tree is particularly helpful when working toward a nonpunitive approach in an organization.

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

<http://www.patientsafety.va.gov/professionals/onthejob/rca.asp>

The National Center for Patient Safety uses a multi-disciplinary team approach, known as Root Cause Analysis - RCA - to study health care-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.

6. 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

7. Patient- and Family-Centered Care Organizational Self-Assessment Tool

<http://www.ihl.org/resources/Pages/Tools/PatientFamilyCenteredCareOrganizationalSelfAssessmentTool.aspx>

This self-assessment 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). It 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.

8. Plan-Do-Study-Act (PDSA) Worksheet

<http://www.ihl.org/resources/Pages/Tools/PlanDoStudyActWorksheet.aspx>

The Plan-Do-Study-Act (PDSA) Worksheet from the Institute for Healthcare Improvement 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. Quality Improvement Fundamentals Toolkit

http://www.leadingagency.org/home/assets/File/QI_Fundamentals_toolkit.pdf

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.

10. Using Change Concepts for Improvement

<http://www.ihl.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.

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

<http://www.innovations.ahrq.gov/guide/guideTOC.aspx>

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.

Composite 5. Overall Perceptions of Patient Safety

1. 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.

2. Color-coded Wristband Standardization in Arizona Implementation Toolkit

http://finance.azhha.org/patient_safety/wristbandtoolkit.pdf

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, allergies, or who 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.

3. Hand Hygiene in Healthcare Settings

<http://www.cdc.gov/handhygiene/training.html>

The Centers for Disease Control and Prevention's Hand Hygiene in Healthcare Settings provides health care workers and patients with a variety of resources, including guidelines for providers, patient empowerment materials, the latest technological advances in hand hygiene adherence measurement, frequently asked questions, and links to promotional and educational tools published by the World Health Organization, universities, and health departments.

4. Healthcare Provider Toolkit

<http://www.oneandonlycampaign.org/content/healthcare-provider-toolkit>

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

5. Patient Safety Primer: Checklists

<https://psnet.ahrq.gov/primers/primer/14>

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 on 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.

6. Patient Safety Primer: Safety Culture

<https://psnet.ahrq.gov/primers/primer/5>

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.

7. Patient Safety Self-Assessment Tool

<http://www.ihl.org/resources/Pages/Tools/PatientSafetySelfAssessmentTool.aspx>

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

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

<http://www.ahrq.gov/professionals/quality-patient-safety/patient-safety-resources/resources/cdifftoolkit/cdifftoolkit.pdf>

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.

9. Tools for Reducing Central Line-Associated Blood Stream Infections

<http://www.ahrq.gov/professionals/education/curriculum-tools/clabsitools/index.html>

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.

Composite 6. Feedback and Communication About Error

1. Patient Safety Workshop – Learning From Error

http://www.who.int/patientsafety/activities/technical/vincristine_learning-from-error.pdf

Developed by the World Health Organization, this patient safety workshop is designed to be suitable for health-care workers (e.g., nurses, doctors, midwives, pharmacists), health care workers in training (e.g., nursing students, medical students, residents), health care managers or administrators, patient safety officers, and any other groups involved in delivering health care.

The workshop explores how multiple weaknesses present within the hospital system can lead to error. It aims to provide all health care workers and managers with insight into the underlying causes of such events. Workshop participants should be introduced to an understanding of why errors occur; begin to understand which actions can be taken to improve patient safety; be able to describe why there should be greater emphasis on patient safety in hospitals; and identify local policies and procedures to improve the safety of care to patients.

2. Provide Feedback to Front-Line Staff

<http://www.ihl.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.ihl.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.

Cross-references to resources already described:

- Composite 2. Supervisor/Manager Expectations and Actions Promoting Patient Safety and Composite 3. Management Support for Patient Safety, #1 [Appoint a Safety Champion for Every Unit](#)
- Composite 2. Supervisor/Manager Expectations and Actions Promoting Patient Safety and Composite 3. Management Support for Patient Safety, #2 [Conduct Patient Safety Leadership WalkRounds™](#)

Composite 7. Communication Openness

1. Rapid Response Team Record with SBAR

<http://www.ihl.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.ihl.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.

- “Guidelines for Communicating With Physicians Using the SBAR Process” explains how to carry out the SBAR technique.
- “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.

3. SBAR Training Scenarios and Competency Assessment

<http://www.ihl.org/resources/Pages/Tools/SBARTrainingScenariosandCompetencyAssessment.aspx>

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

Cross-references to resources already described:

- Composite 1. Teamwork within Units, #2 [Crisis Management Simulation Course](#)
- Composite 1. Teamwork within Units, #5 [Pennsylvania Patient Safety Advisory](#)

Composite 8. Frequency of Events Reported

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

<https://innovations.ahrq.gov/profiles/multifaceted-program-increases-reporting-potential-errors-leads-action-plans-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 Primer: Voluntary Patient Safety Event Reporting (Incident Reporting)

<https://psnet.ahrq.gov/primers/primer/13>

This AHRQ primer provides background information on voluntary patient safety event reporting (incident reporting), including key components of an effective event reporting system, limitations of event reporting, and how event reports can be used to improve safety.

3. 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.

4. Voluntary System to Report and Analyze Nursing Errors Leads to Patient Safety Improvements

<https://innovations.ahrq.gov/profiles/voluntary-system-report-and-analyze-nursing-errors-leads-patient-safety-improvements>

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.

Composite 9. Teamwork Across Units

1. Improving Patient Flow and Reducing Emergency Department Crowding: A Guide for Hospitals

<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.

Cross-references to resources already described:

- Composite 1. Teamwork within Units #3 [Emergency Severity Index \(ESI\): A Triage Tool for Emergency Department Care—Implementation Handbook, 2012 Edition](#)
- Composite 1. Teamwork within Units, #4 [Patient Safety Primer: Teamwork Training](#)
- Composite 1. Teamwork within Units, #5 [Pennsylvania Patient Safety Advisory](#)
- Composite 1. Teamwork within Units, #6 [TeamSTEPPS® — Team Strategies and Tools to Enhance Performance and Patient Safety](#)

Composite 10. Staffing

1. Achieving Efficiency: Lessons From Four Top-Performing Hospitals

http://www.commonwealthfund.org/~media/Files/Publications/Case%20Study/2011/Jul/1528_Edwards_achieving_efficiency_synthesis_four_top_hosps_v3.pdf

This report from the Commonwealth Fund presents case studies of four of the 13 Leapfrog Group-designated “Highest Value Hospitals” that offer strategies that may help hospital and health system leaders achieve greater efficiency. During site visits conducted in 2010, hospital leaders and staff were asked about the activities they credit with having contributed to high quality and low resource use. Managing staffing and adjusting roles to reduce or improve handoffs and promote teamwork to meet patient needs was cited as a way to increase efficiency.

2. Hospital Nurse Staffing and Quality of Care

<http://www.ahrq.gov/research/findings/factsheets/services/nursestaffing/index.html>

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.

3. Implementing Clinical Nurse Leader Role Improves Core Measures Performance, Patient and Physician Satisfaction and Reduces Nurse Turnover

<https://innovations.ahrq.gov/profiles/implementing-clinical-nurse-leader-role-improves-core-measures-performance-patient-and>

St. Louis Medical Center created a new position—the clinical nurse leader—to play a variety of clinical roles, leading to improved performance on Centers for Medicare & Medicaid Services core measures, lower nurse turnover, and higher patient and physician satisfaction.

4. Medicaid Return on Investment Template

<http://www.chcs.org/resource/the-medicaid-return-on-investment-template/>

In connection with the Business Case for Quality initiative, researchers at the University of North Carolina at Chapel Hill developed the Return on Investment (ROI) Template. This Microsoft Excel-based tool is designed for use by States and health plans to retrospectively measure the ROI from quality improvement initiatives and can help users build the business case for increased staffing in their hospitals. Through the Template, users track the financial investment associated with developing and implementing a quality initiative, as well as any savings derived from resulting changes in medical expenditures among the target population.

5. Multifaceted Hospital Program Implemented Over a Decade Leads to Lower Nurse Turnover and Length of Stay, Improved Patient Outcomes, and Enhanced Revenues
<https://innovations.ahrq.gov/profiles/multifaceted-hospital-program-implemented-over-decade-leads-lower-nurse-turnover-and-length>

Over a 10-year period, Hackensack University Medical Center designed a set of strategies to improve nurse satisfaction, reduce length of stay, and enhance case management for selected conditions, leading to improvements, including reductions in nurse turnover and length of stay.

6. Nurse-Led, Unit-Based Quality Improvement Increases Amount of Time Spent With Patients, Reduces Falls and Nurse Turnover
<https://innovations.ahrq.gov/profiles/nurse-led-unit-based-quality-improvement-increases-amount-time-spent-patients-reduces-falls>

Seton Northwest Hospital continuously designs and tests nurse-led quality improvement projects at the patient's bedside, allowing nurses to be more efficient and spend more time with patients, reducing falls and nurse turnover, accelerating patient discharge, and yielding positive feedback from staff and patients.

7. Patient Safety Primer: Missed Nursing Care
<https://psnet.ahrq.gov/primers/primer/29>

This AHRQ primer highlights the importance of nurses to safety culture. Missed nursing care is a subset of the category known as error of omission. It refers to needed nursing care that is delayed, partially completed, or not completed at all. Missed nursing care is problematic because nurses coordinate, provide, and evaluate many interventions prescribed by others to treat illness in hospitalized patients. Nurses also plan, deliver, and evaluate nurse-initiated care to manage patients' symptoms and responses to care. Thus, missed nursing care not only constitutes a form of medical error that may affect safety, but also has been deemed to be a unique type of medical underuse.

Missed nursing care is linked to patient harm including falls and infections. Organizations can prevent missed nursing care by ensuring appropriate nurse staffing, promoting a positive safety culture, and making sure needed supplies and equipment are readily available.

8. Residency Program for First-Year Nurses Eases Entry Into Profession, Producing Well-Above Average Retention Rates
<https://innovations.ahrq.gov/profiles/residency-program-first-year-nurses-eases-entry-profession-producing-well-above-average>

This featured profile is available on the Agency for Healthcare Research and Quality's Health Care Innovations Exchange Web site. Marquette University College of Nursing runs a 1-year residency program for first-year nurses at 53 Wisconsin hospitals. Known as the Wisconsin Nurse Residency Program, the initiative is intended to help first-year nurses better adjust to their new careers. The junior nurses are paired with veteran nurses who provide clinical coaching on

the job; they also attend monthly 6.5-hour classes on critical issues and follow a professional development plan tailored to their needs.

9. State-Mandated Nurse Staffing Levels Alleviate Workloads, Leading to Lower Patient Mortality and Higher Nurse Satisfaction

<https://innovations.ahrq.gov/profiles/state-mandated-nurse-staffing-levels-alleviate-workloads-leading-lower-patient-mortality?id=3708>

This featured profile is available on the Agency for Healthcare Research and Quality's Health Care Innovations Exchange Web site. As mandated by State law, the California Department of Health Services requires acute care hospitals to maintain minimum nurse-to-patient staffing ratios. Required ratios vary by unit, ranging from 1:1 in operating rooms to 1:6 on psychiatric units. The legislation also requires that hospitals maintain a patient acuity classification system to guide additional staffing when necessary, assign certain nursing functions only to licensed registered nurses, determine the competency of and provide appropriate orientation to nurses before assigning them to patient care, and keep records of staffing levels. To assist with compliance, the legislation made grants available to hospitals and provided funding to college and university nursing programs to increase the pipeline of new nurses. The legislation has increased nurse staffing levels and created more reasonable workloads for nurses in California hospitals, leading to fewer patient deaths and higher levels of job satisfaction than in other States without mandated staffing ratios. Despite initial concerns from opponents, the skill mix of nurses used by California hospitals has not declined since implementation of the mandated ratios.

10. Workforce 2015: Strategy Trumps Shortage

<http://www.aha.org/content/00-10/workforce2015report.pdf>

This report from the American Hospital Association presents findings and recommendations hospitals and their associations can use to develop successful workforce strategies. The report includes four sections: the developing workforce challenges; redesigning work; retaining existing workers; and attracting the new generation of workers.

Composite 11. Handoffs and Transitions

1. Coordinated-Transitional Care Toolkit

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

This tool was developed by the University of Wisconsin-Madison School of Medicine & Public Health and the William S Middleton Memorial Veterans Hospital. 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 post-hospital 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 post-discharge outcomes such as reduced medication discrepancies. The toolkit is designed to help clinicians and researchers execute the C-TraC program protocol. In addition to the full toolkit, C-TraC developed a COMPASS module to support hospital to nursing home transitions.

2. Door-to-Doc Patient Safety Toolkit

<http://www.bannerhealth.com/About+Us/Innovations/DoortoDoc/Using+the+D2D+Toolkit.htm>

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. A main feature is that patient flow is split into “less sick” and “sicker” patient subgroups based on a “quick look” rather than a full triage. This has the advantage of keeping less sick patients, which is the vast majority, flowing (rather than waiting in the lobby) during busy times.

3. I-PASS Handoff Bundle

<http://www.ipasshandoffstudy.com/materialsrequest> (requires free account setup and login)

The I-PASS Handoff Bundle was created by [The I-PASS Study Group](#) to teach a standardized approach to handoffs in inpatient settings. This collection is a comprehensive, evidence-based, and consensus-driven suite of educational materials created for a multisite study that consists of six major complementary components.

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

<http://www.ihi.org/resources/Pages/Tools/ISHAPEDPatientCenteredNurseShiftChangeBedsideReport.aspx>

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 an additional layer of safety by enabling the patient to communicate potential safety concerns.

5. ISMP’s List of Confused Drug Names

<http://www.ismp.org/Tools/confuseddrugnames.pdf>

Drawing on information gathered from the ISMP Medication Errors Reporting Program, this Web page 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 tall man lettering in order to prevent such errors.

6. Multi-Center Medication Reconciliation Quality Improvement Study (MARQUIS) Toolkit

<https://innovations.ahrq.gov/qualitytools/multi-center-medication-reconciliation-quality-improvement-study-marquis-toolkit>

The goal of MARQUIS (Multi-Center Medication Reconciliation Quality Improvement Study) 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.

The toolkit includes the following materials:

- The MARQUIS Medication Implementation Manual: A Guide for Medication Reconciliation Quality Improvement
- Training videos illustrating strategies for taking a medication history and providing discharge medication counseling
- A return-on-investment calculator for medication reconciliation quality improvement investments

7. Medication Reconciliation Flowsheet

<http://www.ihl.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.

8. Medication Reconciliation Review: Data Collection Form

<http://www.ihl.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.

9. Medications at Transitions and Clinical Handoffs (MATCH) Toolkit for Medication Reconciliation: Work Plan

<http://www.ahrq.gov/professionals/quality-patient-safety/patient-safety-resources/resources/match/matchap.html>

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 work plan supports implementation of MATCH by providing a central place to document key team decisions and outcomes related to the project. It is a support document to operationalize that process for your

facility. It also serves as a reference to keep the team on track throughout the process of planning, implementation, and analysis.

10. Perioperative Patient “Hand-Off” Toolkit

<https://www.aorn.org/guidelines/clinical-resources/tool-kits/patient-hand-off-tool-kit>

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.

11. RED (Re-Engineered Discharge) Toolkit

<http://www.ahrq.gov/professionals/systems/hospital/red/toolkit/index.html>

Various forces are pushing hospitals to improve their discharge processes to reduce readmissions. Researchers at Boston University Medical Center developed the Re-Engineered Discharge (RED), which was shown to be effective at reducing readmissions and posthospital emergency department visits. This toolkit is designed to assist hospitals, particularly those that serve diverse populations, to replicate the RED. 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

12. “Same Page” Transitional Care Resources for Patients and Care Partners

<http://www.ihl.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.

13. Transitioning Newborns from NICU to Home: A Resource Toolkit

http://www.ahrq.gov/professionals/systems/hospital/nicu_toolkit/index.html

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.

14. 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.

Cross-references to resources already described:

- Composite 1. Teamwork within Units #3 [Emergency Severity Index \(ESI\): A Triage Tool for Emergency Department Care—Implementation Handbook, 2012 Edition](#)

Composite 12. Nonpunitive Response to Error

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

http://www.nahq.org/uploads/NAHQ_call_to_action_FINAL.pdf

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.ihl.org/resources/Pages/Tools/LeadershipResponseSentinelEventEffectiveCrisisMgmt.aspx>

This page of resources 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>

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

4. Patient Safety and the “Just Culture”

http://www.health.ny.gov/professionals/patients/patient_safety/conference/2007/docs/patient_safety_and_the_just_culture.pdf

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

Cross-references to resources already described:

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

General Resources

12. 10 Patient Safety Tips for Hospitals

<http://www.ashrm.org/resources/patient-safety-portal/index.dhtml#tips>

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.

13. 10 Tips to Help Promote Patient Safety

<http://www.ashrm.org/resources/patient-safety-portal/index.dhtml#tips>

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

14. 2011 ISMP Medication Safety Self Assessment[®] for Hospitals

<http://www.ismp.org/selfassessments/hospital/2011/pdfs.asp>

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

15. 2014 National Healthcare Quality and Disparities Report: Chartbook on Patient Safety

<http://www.ahrq.gov/research/findings/nhqdr/2014chartbooks/patientsafety/>

This Patient Safety chartbook is part of a family of documents and tools that support the National Healthcare Quality and Disparities Report (QDR). This chartbook includes a summary of trends across measures of patient safety from the QDR and figures illustrating select measures of patient safety. A PowerPoint version is also available that users can download for presentations.

16. 2015 National Patient Safety Goals Critical Access Hospital Program

http://www.jointcommission.org/assets/1/6/2015_CAH_NPSG_ER.pdf

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.

17. 2015 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.

18. Always Events[®] Toolbox

<http://alwaysevents.pickerinstitute.org/?p=992>

The Picker Institute, Inc. provides 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[®].

19. AHRQ Impact Case Studies

http://www.ahrq.gov/policymakers/case-studies/index.html?search_api_views_fulltext=patient+safety

AHRQ's evidence-based tools and resources are used by organizations nationwide to improve the quality, safety, effectiveness, and efficiency of health care. This subset of the Agency's Impact Case Studies specific to patient safety highlights these successes, describing the use and impact of AHRQ-funded tools by State and Federal policymakers, health systems, clinicians, academicians, and other professionals.

20. CAHPS® Improvement Guide

<https://cahps.ahrq.gov/quality-improvement/improvement-guide/improvement-guide.html>

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. This guide includes new improvement interventions and offers additional resources.

21. Hospital Guide to Reducing Medicaid Readmissions

<http://www.ahrq.gov/professionals/systems/hospital/medicaidreadmitguide/index.html>

The Agency for Healthcare Research and Quality commissioned this guide to identify ways evidence-based strategies to reduce readmissions can be adapted or expanded to better address the transitional care needs of the adult Medicaid population. This toolkit aims to provide information for hospitals to help reduce preventable readmissions among Medicaid patients. The guide explains ways to determine root causes of readmissions, evaluate existing interventions, develop a set of improvement strategies, and enhance care transition processes.

22. Department of Defense Patient Safety Program

<http://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Quality-And-Safety-of-Healthcare/Patient-Safety/Patient-Safety-Products-And-Services/Toolkits>

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). Patient Safety Program Toolkits are available and intended to be small, self-contained resource modules for training and application. Toolkits are designed with the following use in mind for anyone on the healthcare team:

- Use a toolkit as a reference and information source for a specific tool subject.
- Combine a toolkit into existing course work to introduce team members to the tool's key concepts and its use on clinical units.
- Use a toolkit to create and deliver training on a specific tool.

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

<http://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/final-reports/advisorycouncil/advisorycouncil.pdf>

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.

24. Hospital Inpatient Waste Identification Tool

<http://www.ihi.org/resources/Pages/IHIWhitePapers/HospitalInpatientWasteIDToolWhitePaper.aspx>

The Hospital Inpatient Waste Identification Tool provides a systematic method for hospital frontline clinical staff, members of the financial team, and leaders to identify clinical and operational waste and subsequently prioritize and implement waste reduction initiatives that will result in cost savings for the organization. The tool consists of five modules — Ward Module, Patient Care Module, Diagnosis Module, Treatment Module, and Patient Module — that qualitatively identify opportunities for waste reduction. Each module includes clearly articulated waste types, worksheets, and instructions.

25. Medically Induced Trauma Support Services (MITSS)

<http://www.mitsstools.org/tool-kit-for-staff-support-for-healthcare-organizations.html>

Medically Induced Trauma Support Services (MITSS), Inc. a non-profit organization whose mission is “to support healing and restore hope” to patients, families, and clinicians who have been affected by an adverse medical event, developed a toolkit for clinician support. MITSS also provides an organizational assessment tool and a comprehensive work plan.

26. Minnesota Alliance for Patient Safety Culture Road Map

<http://mnpatientsafety.org/Culture-Road-Map>

The Minnesota Alliance for Patient Safety, a partnership among the Minnesota Hospital Association, Minnesota Medical Association, Minnesota Department of Health, and more than 50 other public and private health care organizations, has developed a safety culture road map for organizations working toward a culture of safety.

27. Partnering to Heal: Teaming-Up Against Healthcare-Associated Infections

<http://www.health.gov/hcq/training.asp>

This training program from the U.S. Department of Health and Human Services highlights effective communication about infection control practices and ideas for creating a culture of safety to prevent health care–associated infections.

28. Patient Safety in Small Rural Hospitals

<http://www.unmc.edu/patient-safety/surveys/>

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.

29. Patient Safety Primer: Medication Errors

<https://psnet.ahrq.gov/primers/primer/23>

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.

30. Premier Safety Institute®

<https://legacy.premierinc.com/quality-safety/tools-services/safety/>

The Premier Safety Institute® provides safety resources and tools to promote a safe health care delivery environment for patients, workers, and their communities. The Safety Web site assembles timely information and technical resources that help busy healthcare professionals effectively tackle the challenge of preventing medical errors and fostering a safe and healthy healthcare environment for everyone.

31. Quality Improvement Savings Tracker Worksheet

<http://www.ihl.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.

32. SAFER Guides

<http://www.healthit.gov/policy-researchers-implementers/safer>

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

recommended practices. Each SAFER Guide has extensive references and is available as a downloadable PDF and as an interactive web-based tool.

Areas addressed include:

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

33. Targeted Medication Safety Best Practices for Hospitals

<http://www.ismp.org/Tools/BestPractices/default.aspx>

The Institute for Safe Medication Practices (ISMP) has issued six 2014-15 Targeted Medication Safety Best Practices for hospitals. Developed with the help of leading medication safety experts, and patterned after the Joint Commission's National Patient Safety Goals, the best practices are designed to help alert hospitals and focus their efforts on errors that cause serious patient harm despite being reported many times in ISMP alerts.

34. 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.