Improving Patient Safety in Hospitals: A Resource List for Users of the AHRQ Hospital Survey on Patient Safety Culture Version 2.0

I. Purpose

This document provides a list of references to websites and other publicly available practical resources hospitals can use to improve patient safety culture and patient safety. While this resource list is not exhaustive, it is designed to give initial guidance to hospitals seeking information about patient safety initiatives.

II. How To Use This Resource List

Resources are listed in alphabetical order, organized by the Surveys on Patient Safety Culture™ (SOPS™) Hospital Survey Version 2.0 composite measures assessed in the Agency for Healthcare Research and Quality (AHRQ) Hospital SOPS Version 2.0, followed by general resources.

For easy access to the resources, keep the file open rather than printing it, because many of the website URLs are hyperlinked and cross-referenced to other resources within the document.

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

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.

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III. Contents

IV. Resources by Composite

The following resources are organized according to the relevant AHRQ Hospital Survey on Patient Safety Culture composite measures they are designed to help improve. Some resources are duplicated (and cross-referenced) since they apply to more than one composite.

Composites 1 and 2. Supervisor, Manager, or Clinical Leader Support for Patient Safety and Hospital Management Support for Patient Safety

1. **Conduct Patient Safety Leadership WalkRounds™**
   http://www.ihi.org/resources/Pages/Changes/ConductPatientSafetyLeadershipWalkRounds.aspx
   http://www.ihi.org/resources/Pages/Tools/PatientSafetyLeadershipWalkRounds.aspx
   (both items require free account setup and login)

   Senior leaders can demonstrate their commitment to safety and learn about the safety issues in their organization by making regular rounds for the sole purpose of discussing safety with staff. These Institute for Healthcare Improvement (IHI) web pages discuss the benefits of management making regular rounds and give tips for doing the rounds, as well as links to resources. These rounds are especially effective in conjunction with safety briefings.

2. **Framework for Effective Board Governance of Health System Quality**
   http://www.ihi.org/resources/Pages/IHIWhitePapers/Framework-Effective-Board-Governance-Health-System-Quality.aspx (requires free account setup and login)

   The Institute for Healthcare Improvement (IHI) Lucian Leape Institute conducted a research scan on board governance of health system quality, an evaluation of governance education in quality, and expert interviews. This work made it clear that board members, and those who support them, want a clear and consistent framework to guide governance of all dimensions of quality beyond safety, including identifying the core processes and necessary activities for effective governance of quality. The framework, assessment tool, and support guides strive to reduce variation in and clarify trustee responsibilities for quality oversight. They also provide practical tools for trustees and the health system leaders who support them to govern quality in a way that will deliver better care to patients and communities.

3. **A Framework for Safe, Reliable, and Effective Care**
   http://www.ihi.org/resources/Pages/IHIWhitePapers/Framework-Safe-Reliable-Effective-Care.aspx (requires free account setup and login)

   The Framework for Safe, Reliable, and Effective Care describes the key strategic, clinical, and operational components involved in achieving safe and reliable operational excellence—a "system of safety," not just a collection of standalone safety improvement projects.

4. **Leadership Role in Improving Safety**
   https://psnet.ahrq.gov/primers/primer/32?utm_source=EN&utm_medium=EN&utm_term=1&utm_content=8&utm_campaign=AHRQ_PSP_2016

   This Patient Safety Primer discusses the role of organizational leadership in improving patient safety. The crucial roles that frontline and midlevel providers play in improving safety are discussed in the related Safety Culture and High Reliability Patient Safety Primers.

5. **Leading a Culture of Safety: A Blueprint for Success**
   http://www.ihi.org/resources/Pages/Publications/Leading-a-Culture-of-Safety-A-Blueprint-for-Success.aspx (requires free account setup and login)

   Leading a Culture of Safety: A Blueprint for Success was developed to bridge gaps in knowledge and resources by providing chief executive officers and other healthcare leaders with a useful tool for assessing and advancing their organization's safety culture. This guide can be used to help determine the current state of an organization's journey, inform dialogue with the board and leadership team, and help leaders set priorities.

6. **Patient Safety Initiative: Hospital Executive and Physician Leadership Strategies**
   https://www.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. The Joint Commission Resources Hospital Engagement Network team developed this 39-page toolkit as part of the national Partnership for Patients initiative. The toolkit includes a concise synopsis of activities that help leaders and medical staff members activate their support for patient safety.

7. **Safety Briefings and Safety Huddles**
   Two resources are available for conducting safety briefings and safety huddles with the goal of increasing safety awareness among frontline staff and helping develop a culture of safety.

   a. **Safety Huddle Results Collection Tool**
      http://www.ihi.org/resources/Pages/Tools/SafetyHuddleResultsCollectionTool.aspx
      (requires free account setup and login)

      This tool can be used to aggregate data collected during tests of safety briefings (also called "safety huddles"). When organizations first test 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 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.

b. Guide to Safety Huddles
http://www.wsha.org/wp-content/uploads/Worker-Safety_SafetyHuddleToolkit_3_27_15.pdf

This guide to conducting safety huddles defines a safety huddle and suggests who should attend, when they should occur, and how to start a huddle program. Appendixes include safety huddle process maps, templates, and tools.

Cross-references to other resource(s) in this document:

- Composite 8, Response to Error, #2, Leadership Response to a Sentinel Event: Respectful, Effective Crisis Management

Composite 3. Teamwork

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

The Comprehensive Unit-based Safety Program (CUSP) is a method that can help clinical teams make care safer by combining improved teamwork, clinical best practices, and the science of safety. The Core CUSP toolkit gives clinical teams the training resources and tools to apply the CUSP method and build their capacity to address safety issues. This toolkit is modular and modifiable to meet individual unit needs. Each module includes teaching tools and resources to support change at the unit level, presented through facilitator notes that take users through the module step by step, presentation slides, tools, and videos.

2. IHI Disruptive Behavior Videos

a. A Slap on the Hand.
http://www.ihi.org/education/IHIOpenSchool/resources/Pages/Activities/DisruptiveBehaviorPart1ASlapontheHand.aspx (requires free account setup and login)

This short video and discussion guide provides an example of disruptive behavior, describes how it can harm teamwork, and provides techniques to improve damaged relationships.

b. How Can Disruptive Behavior Be Harmful?
http://www.ihi.org/education/IHIOpenSchool/resources/Pages/Activities/DisruptiveBehaviorPart2TheControllingBoss.aspx (requires free account setup and login)

This short video and discussion guide describes how disruptive behavior can lead to patient harm, the importance of responding to disruptive behavior, and steps to take when experiencing or witnessing disruptive behavior.

3. **Pennsylvania Patient Safety Advisory (Vol.7, Suppl. 2)**
   http://patientsafety.pa.gov/ADVISORIES/documents/2010sup2_home.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. Three articles are included on the following topics:

   - Building a Culture of Operating Room Safety Using Crew Resource Management
   - Chain of Command: When Disruptive Behavior Affects Communication and Teamwork
   - Patient Safety Is Enhanced by Teamwork

4. **TeamSTEPPS® — Team Strategies and Tools to Enhance Performance and Patient Safety**
   www.ahrq.gov/teamstepps

   TeamSTEPPS is a teamwork system designed for healthcare professionals that is:

   - A powerful solution to improving patient safety within an organization.
   - An evidence-based teamwork system to improve communication and teamwork skills among healthcare professionals.
   - A source for ready-to-use materials and a training curriculum to successfully integrate teamwork principles into all areas of a healthcare system.
   - Scientifically rooted in more than 20 years of research and lessons from the application of teamwork principles.
   - Developed by the Department of Defense's Patient Safety Program in collaboration with AHRQ.

   The TeamSTEPPS curriculum is an easy-to-use comprehensive multimedia kit that contains:

   - Fundamentals modules in text and presentation format.
   - A pocket guide that corresponds with the essentials version of the course.
   - Video vignettes to illustrate key concepts.
   - Workshop materials on change management, coaching, and implementation.

Composite 4. Communication Openness

1. **Raising and Responding to Concerns**
   https://psnet.ahrq.gov/resources/resource/28738/Raising-and-Responding-to-Concerns

   Staff willingness to speak up when they are concerned about unsafe behaviors and conditions is a hallmark of safety culture. This website links to videos that use vignettes to demonstrate challenges to speaking up in healthcare, ways open communication can prevent errors, strategies to raise concerns on the frontline, and benefits of using checklists to support conversation.

2. **WIHI: How To Speak Up for Safety**
   http://www.ihi.org/resources/Pages/AudioandVideo/WIHI-Speak-Up-For-Safety.aspx
   (freely available podcast; requires free account setup and login for related slides and other materials)

   Many staff members think that robust safety cultures are so common in healthcare organizations today, everyone is comfortable pointing out missteps and discrepancies to their colleagues and even getting better at bringing them to the attention of their supervisors. But that is not always the case. This webcast provides information on why this practice is not more common and how to speak up for safety.

Cross-references to other resource(s) in this document:

- Composite 3. Teamwork, #3, Pennsylvania Patient Safety Advisory

Composite 5. Reporting Patient Safety Events

1. **6 Near Miss Reporting Form Examples You'll Want To Copy**
   http://www.perillon.com/blog/near-miss-reporting-form-examples

   This website has gathered six near-miss reporting form examples from around the web. They can be used to help create or update a near-miss reporting form.

2. **Developing a Reporting Culture: Learning From Close Calls and Hazardous Conditions**
   https://psnet.ahrq.gov/resources/resource/32494

   This new sentinel event alert from The Joint Commission explores how organizations can change their culture to promote reporting. It highlights bright spots: organizations that use a just culture approach to investigating errors, celebrate employees who report safety hazards, and have leaders who prioritize reporting. The Joint Commission proposes actions for all organizations to take, including developing incident reporting systems, promoting leadership buy-in, engaging in systemwide communication, and implementing transparent accountability structures. An Annual Perspective reviewed the context of the no-blame movement and the recent shift toward a framework of a just culture.

3. **Good Catch/Near Miss Campaign Toolkit**
   https://info.americandatanetwork.com/good-catch-campaign-toolkit
   https://info.americandatanetwork.com/good-catch-near-miss-campaign-case-study (requires request form to be completed for free access)

   While experts consider near-misses to be unmatched predictors of medical error, research shows they are markedly underreported. This toolkit provides a variety of materials organizations can use to run a Good Catch Campaign to increase reporting of near-misses. It also includes a case study of 45 hospitals that ran the same campaign and increased their near-miss reporting by 47 percent.

4. **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 AHRQ's Health Care Innovations Exchange website. 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.

5. **Patient Safety Primer: Reporting Patient Safety Events**
   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 ways event reports can be used to improve safety.

Composite 6. Organizational Learning—Continuous Improvement

1. **Common Cause Analysis: Focus on Institutional Change**
   https://www.psqh.com/analysis/common-cause-analysis/#
   https://www.ahrq.gov/downloads/pub/advances2/vol1/advances-browne_5.pdf

   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 failure to get an accurate view of the "big picture"—common themes and issues affecting safety.

2. **Improvement Capability Self-Assessment Tool**
   http://www.ihi.org/resources/Pages/Tools/IHIImprovementCapabilitySelfAssessmentTool.aspx
   (requires free account setup and login)

   The Improvement Capability Self-Assessment Tool from IHI 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

3. **Patient Safety Primer: Debriefing for Clinical Learning**
   https://psnet.ahrq.gov/primers/primer/36/learning-through-debriefing

   This AHRQ primer provides background information on debriefing for clinical learning, including components of debriefing, tools available, special considerations, and a framework for clinical event debriefing.

4. **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 healthcare workers (e.g., nurses, doctors, midwives, pharmacists), healthcare workers in training (e.g., nursing students, medical students, residents), healthcare managers or administrators, patient safety officers, and any other groups involved in delivering healthcare.

   The workshop explores how multiple weaknesses within the hospital system can lead to error. It aims to provide all healthcare workers and managers with insight into the underlying causes of such events. By the end of the 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 hospitals should place greater emphasis on patient safety; and
   - Identify local policies and procedures to improve the safety of care to patients.

5. **Plan-Do-Study-Act (PDSA) Steps and Worksheet**
   http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementTestingChanges.aspx
   http://www.ihi.org/resources/Pages/Tools/PlanDoStudyActWorksheet.aspx
   (worksheet requires free account setup and login)

   The Plan-Do-Study-Act (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). The first website listed provides the steps in the PDSA cycle and the second website listed provides a PDSA Worksheet, a useful tool for documenting a test of change.

6. **Toolkit for Using the AHRQ Quality Indicators™**
   http://www.ahrq.gov/professionals/systems/hospital/qitoolkit/index.html

   The AHRQ Quality Indicators (QIs) are measures of hospital quality and safety drawn from readily available hospital inpatient administrative data. This toolkit supports hospitals that want to improve performance on 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.

7. **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 decision making and help decision makers determine whether an innovation would be a good fit or an appropriate stretch for their healthcare organization.

Composite 7. Communication About Error

1. **Communication and Optimal Resolution (CANDOR) Toolkit**
   https://www.ahrq.gov/professionals/quality-patient-safety/patient-safety-resources/resources/candor/introduction.html

   Healthcare institutions and practitioners can use the Communication and Optimal Resolution (CANDOR) process to respond in a timely, thorough, and just way when unexpected events cause patients harm. The CANDOR toolkit contains eight modules, each with PowerPoint slides with facilitator notes. Some modules also contain tools, resources, or videos.

   The key lessons for hospitals implementing the CANDOR process in their institutions include how to:

   - Engage patients and families in disclosure communication after adverse events.
   - Implement a Care for the Caregiver program for providers involved in adverse events.
   - Investigate and analyze an adverse event to learn from it and prevent future adverse events.
   - Review and revise the organization's current processes to align with the CANDOR process.
   - Establish a resolution process for the organization.

2. **Provide Feedback to Front-Line Staff**
   http://www.ihi.org/resources/Pages/Changes/ProvideFeedbacktoFrontLineStaff.aspx (requires free account setup and login)

   Feedback to frontline staff is a critical component of demonstrating a commitment to safety and ensuring that staff members continue to report safety issues. This IHI web page identifies tips and tools for how to communicate feedback.

3. **Shining a Light: Safer Health Care Through Transparency**
   http://www.ihi.org/resources/Pages/Publications/Shining-a-Light-Safer-Health-Care-Through-Transparency.aspx (requires free account setup and login)

   Defining transparency as "the free flow of information that is open to the scrutiny of others," this report offers sweeping recommendations to bring greater transparency in four domains: between clinicians and patients; among clinicians within an organization; between organizations; and between organizations and the public.

It makes the case that true transparency will result in improved outcomes, fewer medical errors, more satisfied patients, and lower costs of care. Case studies are included to document how transparency is practiced in each domain.

Cross-references to other resource(s) in this document:

- Composites 1 and 2. Supervisor, Manager, or Clinical Leader Support for Patient Safety and Hospital Management Support for Patient Safety
    - #1, Conduct Patient Safety Leadership WalkRounds™
    - #7, Safety Briefings and Safety Huddles

Composite 8. Response to Error

1. **The Incident Decision Tree: Guidelines for Action Following Patient Safety Incidents**
   https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patient-safety-resources/resources/advances-in-patient-safety/vol4/Meadows.pdf

   The National Patient Safety Agency developed the Incident Decision Tree to help National Health Service managers in the United Kingdom determine a fair and consistent course of action toward staff involved in patient safety incidents. Staff can use this decision tree when analyzing an error or adverse event in an organization to help identify how human factors and systemic issues contributed to the event. The Incident Decision Tree supports the aim of creating an open culture, where employees feel able to report patient safety incidents without undue fear of the consequences.

2. **Leadership Response to a Sentinel Event: Respectful, Effective Crisis Management**
   http://www.ihi.org/resources/Pages/Tools/LeadershipResponseSentinelEventEffectiveCrisisMgmt.aspx (requires free account setup and login)

   IHI developed this page of resources. 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.

   a. **Nursing 2015 Just Culture Toolkit**
      https://nursing2015.wordpress.com/blue-team/blue-team-documents/just-culture-tool-kit-building/

      This website provides a definition of Just Culture, presentations on Just Culture, a case study, and videos.

b. Just Culture
https://www.unmc.edu/patient-safety/patientsafetyculture/just-culture.html

This website provides links to ways to engage in and teach about a Just Culture, execute a Just Culture, and evaluate a Just Culture.

c. Outcome Engenuity
https://www.outcome-eng.com/david-marx-introduces-just-culture/

This website provides resources and videos on Just Culture.

3. Living a Culture of Patient Safety Policy and Brochure
http://www.ihi.org/resources/Pages/Tools/LivingaCultureofPatientSafety.aspx (requires free account setup and login)

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

5. Root Cause Analysis

a. 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 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."

b. Root Cause Analysis in Health Care: Tools and Techniques
https://www.jcrinc.com/assets/1/14/EBRCA15Sample.pdf

This document is intended to help healthcare organizations prevent system failures by using root cause analysis to:

- Identify causes and contributing factors of a sentinel event or a cluster of incidents.
- Identify system vulnerabilities that could lead to patient harm.
- Implement risk reduction strategies that decrease the likelihood of a recurrence of the event or incidents.

- Determine effective and efficient ways of measuring and improving performance.

c. **RCA2: Improving Root Cause Analyses and Actions To Prevent Harm**
http://www.ihi.org/resources/Pages/Tools/RCA2-Improving-Root-Cause-Analyses-and-Actions-to-Prevent-Harm.aspx (requires free account setup and login)

With a grant from The Doctors Company Foundation, the National Patient Safety Foundation convened a panel of subject matter experts and stakeholders to examine best practices around RCAs. The panel developed guidelines to help health professionals standardize the process and improve the way they investigate medical errors, adverse events, and near-misses. To focus on the objective of preventing future harm, this updated process focuses on actions to be taken: Root Cause Analyses and Actions, or RCA2 (RCA "squared").

Cross-references to other resource(s) in this document:

- Composite 5. Reporting Patient Safety Events
  - #2, Developing a Reporting Culture: Learning From Close Calls and Hazardous Conditions
  - #4, Multifaceted Program Increases Reporting of Potential Errors, Leads to Action Plans To Enhance Safety
- Composite 9. Handoffs and Information Exchange, #6, SBAR Tool: Situation-Background-Assessment-Recommendation

Composite 9. Handoffs and Information Exchange

1. **10 Patient Handoff Communication Tools**
https://www.beckersasc.com/asc-quality-infection-control/10-patient-handoff-communications-tools-2014.html

Shift changes, patient handoffs, and referrals all require precise transfers of patient information. Many things can go wrong, however, and plenty of research has shown deficient patient handoffs can be hazardous to patient safety. This article lists 10 tools to assist in better patient handoff communications and to avoid errors.

2. **Improving Patient Flow and Reducing Emergency Department Crowding: A Guide for Hospitals**
http://www.ahrq.gov/research/findings/final-reports/ptflow/index.html

This AHRQ guide presents step-by-step instructions hospitals can use in planning and implementing patient flow improvement strategies to ease emergency department crowding.

3. **I-PASS Handoff Bundle**
http://www.ipasshandoffstudy.com/materialsrequest (requires free account setup and login)

The I-PASS Study Group created the I-PASS Handoff Bundle 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. The I-PASS Study and I-PASS Handoff Bundle were specifically designed to target pediatric resident physicians. However, the I-PASS Handoff Bundle can serve as a framework for handoffs of care for multiple learner types and environments.

4. **ISHAPED Patient-Centered Approach to Nurse Shift Change Bedside Report**
   http://www.ihi.org/resources/Pages/Tools/ISHAPEDPatientCenteredNurseShiftChangeBedsideReport.aspx (requires free account setup and login)

   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.

5. **"Same Page" Transitional Care Resources for Patients and Care Partners**
   http://www.ihi.org/resources/Pages/Tools/SamePageTransitionalCareResourcesforPatientsandCarePartners.aspx (requires free account setup and login)

   These resources and tools were developed for patients and their caregivers or care partners to use when planning 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 healthcare providers to all be "on the same page" in understanding the patient's health and healthcare 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 designed to be useful to patients, care partners, and healthcare teams.

6. **SBAR Tool: Situation-Background-Assessment-Recommendation**
   http://www.ihi.org/resources/Pages/Tools/SBARTechniqueforCommunicationASituationalBriefingModel.aspx
   http://www.ihi.org/resources/Pages/Tools/SBARTrainingScenariosandCompetencyAssessment.aspx (requires free account setup and login)

   The SBAR (Situation-Background-Assessment-Recommendation) technique provides a framework for communication between members of the healthcare team about a patient's condition. This downloadable tool from IHI 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 a provider can use to organize information when preparing to communicate with a physician about a critically ill patient.

   The 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.

7. **A "Ticket to Ride" Protects Patients Off the Unit**
   https://www.nursingcenter.com/journalarticle?Article_ID=858666&Journal_ID=54016&Issue_ID=858618

   The Joint Commission and the National Quality Forum endorse giving appropriate, timely, and accurate information to all healthcare providers and facilities involved in a patient's care. To prevent communication breakdowns, structured handoffs are an essential safeguard as outlined in National Patient Safety Goal 02.05.01.2. This article describes a concise handoff tool, the Ticket to Ride, which helps maintain patient safety and continuity of care when patients temporarily leave their unit.

Cross-references to other resource(s) in this document:

- Composites 1 and 2. Supervisor, Manager, or Clinical Leader Support for Patient Safety and Hospital Management Support for Patient Safety, #7, Safety Briefings and Safety Huddles

Composite 10. Staffing and Work Pace

1. **5 Staffing Strategies for Engaged Nurses and Better Patient Outcomes**
   https://www.apihealthcare.com/sites/default/files/5-Staffing-Strategies-for-Happier-Nurses.pdf

   This document provides six articles on staffing within hospitals:

   - 5 of the Biggest Issues Nurses Face Today
   - Using Staffing Evidence To Improve the Patient Experience
   - How Staffing Variables Impact Patient Outcomes
   - Nurse Work Environment a Key Driver of Performance
   - How To Avoid 3 Common Staffing and Scheduling Pitfalls
   - Solving Staffing Conundrums

2. **Acuity-Adjusted Staffing: A Proven Strategy To Optimize Patient Care**
   https://www.americannursetoday.com/acuity-adjusted-staffing-proven-strategy-optimize-patient-care/

   Nurse staffing is a complex issue. Matching the right nurse to the right patient at the right time requires an understanding of the individual patient's need for care, nurse characteristics, workflows, and context of care, including organizational culture and access to resources. A panel of nurse leaders explored this issue at a roundtable, "Using Acuity: Optimizing Patient Care and Nursing Workload," held in December 2015. This website provides a summary of what the panel presented on research and real-life examples to illustrate how astute determination of patient acuity can optimize patient outcomes and help balance nurse workloads.

3. **Clinical Nurse Leader Tool Kit**
   https://www.aacnnursing.org/Education-Resources/Tool-Kits/Clinical-Nurse-Leader-Tool-Kit

   The American Association of Colleges of Nursing developed the clinical nurse leader (CNL) position in response to complexities of healthcare environments and the need to ensure safety

and high standards at the point of service. The CNL can also help meet diverse client and healthcare environment needs. This website provides sample materials to create this position.

4. **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 is considered 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 ensuring needed supplies and equipment are readily available.

5. **Transforming Care at the Bedside**
   http://www.ihi.org/engage/initiatives/completed/TCAB/Pages/default.aspx (requires free account setup and login)

   Transforming Care at the Bedside was a national initiative developed by the Robert Wood Johnson Foundation in collaboration with IHI that ran from 2003 through 2008 and had three phases. These organizations agreed to work together to create, test, and implement changes that will dramatically improve care on medical-surgical units and improve staff satisfaction. This website provides links to lessons learned and program results.

General Resources

1. **2019 National Patient Safety Goals Hospital Program**
   https://www.jointcommission.org/hap_2017_npsgs/

   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 website 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.

2. **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 healthcare. 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.

3. **AHRQ Patient Safety Education and Training Catalog**
   http://psnet.ahrq.gov/pset

   AHRQ's Patient Safety Education and Training Catalog consists of patient safety programs currently available in the United States. The catalog, featured on AHRQ's Patient Safety Network site, offers a database of patient safety education and training programs, each tagged for easy searching and browsing. The database identifies a number of characteristics of the programs, including clinical area, program and learning objectives, evaluation measures, and cost.

4. **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 IHI website identifies tips for appointing a safety champion.

5. **ASHRM Patient Safety Portal**
   http://www.ashrm.org/resources/patient-safety-portal/

   The American Society for Healthcare Risk Management patient safety portal provides information about patient safety programs, tools, and other important resources.

6. **The CAHPS® Ambulatory Care Improvement Guide: Practical Strategies for Improving Patient Experience**
   https://cahps.ahrq.gov/quality-improvement/improvement-guide/improvement-guide.html

   The extensive and growing use of Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys to assess the quality of health plans, medical groups, and other organizations has created a demand for practical strategies 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.

7. **Department of Defense Patient Safety Program Toolkits & Guides**
   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.

Available toolkits and guides include:

- Briefs and Huddles.
- Debriefs.
- Eliminating Wrong Site Surgery and Procedure Events.
- MHS Leadership Engagement.
- Patient Falls Reduction.
- RCA Resource Guide.
- SBAR.

8. **Fall Prevention in Hospitals Training Program**
   https://www.ahrq.gov/professionals/systems/hospital/fallpxtraining/index.html?utm_source=ahrq&utm_medium=dpils&utm_term=&utm_content=1&utm_campaign=ahrq_fallprevent_2017

   This website provides AHRQ's Fall Prevention Toolkit and the experiences of 10 hospitals that participated in a 2-year pilot project of the training program. Hospitals participating in this pilot implementation of the training program and toolkit reduced their fall and fall with injury rates and sustained these reductions for a year (the period during which hospitals were followed as part of this project). The training program consists of a five-module curriculum and a series of companion webinars on specific topics related to fall prevention. An Implementation Guide suggests additional ways to use the training program and the toolkit.

9. **Framework for Improving Joy in Work**
   http://www.ihi.org/resources/Pages/IHIWhitePapers/Framework-Improving-Joy-in-Work.aspx
   (requires free account setup and login)

   This IHI white paper serves as a guide for healthcare organizations to engage in a participative process where leaders ask colleagues at all levels of the organization, "What matters to you?" This approach enables them to better understand the barriers to joy in work and to create meaningful, high-leverage strategies to address these issues.

10. **Guide to Patient and Family Engagement in Hospital Quality and Safety**
    https://www.ahrq.gov/professionals/systems/hospital/engagingfamilies/index.html

    Research shows that patients' engagement in their healthcare can lead to measurable improvements in safety and quality. To promote stronger engagement, AHRQ developed a guide to help patients, families, and health professionals work together as partners to promote improvements in care.

11. **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 healthcare workers and patients with a variety of resources, including guidelines for providers and patient empowerment materials. Other resources include the latest technological advances in measuring hand hygiene adherence, frequently asked questions, and links to promotional

and educational tools published by the World Health Organization, universities, and health departments.

12. **IHI Patient Safety Essentials Toolkit**
    http://www.ihi.org/resources/Pages/Tools/Patient-Safety-Essentials-Toolkit.aspx
    (requires free account setup and login)

    IHI's Patient Safety Essentials Toolkit includes documents on improving teamwork and communication, tools to help understand the underlying issues that can cause errors, and guidance about how to create and maintain reliable systems. This toolkit contains nine tools, including information on the SBAR technique, Action Hierarchy (a component of RCA2), daily huddle agenda, and Failure Modes and Effects Analysis (FMEA).

13. **ISMP Medication Safety Resources**
    https://www.ismp.org/assessments/hospitals
    http://www.ismp.org/Tools/BestPractices/default.aspx

    The first resource, the Institute for Safe Medication Practices (ISMP) Medication Safety Self Assessment® for Hospitals, is designed to:

    - Heighten awareness of distinguishing characteristics of a safe hospital medication system,
    - Assist interdisciplinary teams in proactively identifying opportunities for reducing patient harm when prescribing, and
    - Create a baseline of efforts to evaluate risk and efforts over time.

    The second resource, ISMP's Targeted Medication Safety Best Practices for Hospitals, was 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.

14. **Moore Foundation Patient and Family Engagement Survey**
    http://www.hret.org/quality/projects/moore_foundation_patient_family_engagement_survey.shtml

    With funding from the Gordon and Betty Moore Foundation, the Health Research and Educational Trust created a downloadable survey for hospital leaders, asking them about their use of patient and family engagement strategies. A report, *A Leadership Resource for Patient and Family Engagement Strategies*, is available to help hospital leaders take the right steps to effectively promote patient and family engagement strategies within their organizations.

15. **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 healthcare-associated infections.

16. **Patient Safety Primer: Checklists**
    https://psnet.ahrq.gov/primers/primer/14

    Most errors in healthcare are defined as slips rather than mistakes, and checklists can help prevent them, according to a patient safety primer available from AHRQ's Patient Safety Network. A checklist is an algorithmic list of actions to be performed in a given clinical setting, with the goal of ensuring that no step is forgotten. 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 situation.

17. **Patient Safety Primer: Culture of Safety**
    https://psnet.ahrq.gov/primers/primer/5

    The concept of safety culture originated outside healthcare 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." AHRQ's Patient Safety Network explains this topic further and provides links to more information on what is new in safety culture.

18. **Patient Safety Self-Assessment Tool**
    http://www.ihi.org/resources/Pages/Tools/PatientSafetySelfAssessmentTool.aspx (requires free account setup and login)

    This organizational self-assessment tool was designed by Steven Meisel, Pharm.D., at Fairview Health Services using information from an AHRQ report. The tool can help staff members evaluate whether known safety practices are in place in their organizations and find areas for improvement.

19. **Patient Safety Primer: Medication Errors and Adverse Drug Events**
    https://psnet.ahrq.gov/primers/primer/23

    This AHRQ primer outlines strategies providers can use at each stage of the medication use pathway—prescribing, transcribing, dispensing, and administration—to prevent adverse drug events (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 and strategies to prevent ADEs.

20. **VA National Center for Patient Safety**
https://www.patientsafety.va.gov/

The Department of Veteran Affairs (VA) established the National Center for Patient Safety in 1999 to develop and nurture a culture of safety throughout the Veterans Health Administration. The center is part of the VA Office of Quality, Safety, and Value. Its goal is the nationwide reduction and prevention of inadvertent harm to patients as a result of their care.

21. **WHO Multi-Professional Patient Safety Curriculum Guide**
https://www.who.int/patientsafety/education/mp_curriculum_guide/en/

The World Health Organization developed the Multi-Professional Patient Safety Curriculum Guide to assist in teaching patient safety in universities and schools in the fields of dentistry, medicine, midwifery, nursing, and pharmacy. The guide also supports the ongoing training of all healthcare professionals. The curriculum guide has two parts. Part A is a teachers' guide designed to introduce patient safety concepts to educators. It relates to building capacity for patient safety education, program planning, and course design. Part B provides all-inclusive, ready-to-teach, topic-based patient safety courses that can be used as a whole or on a per topic basis. The guide covers 11 patient safety topics, each designed to feature a variety of ideas and methods for patient safety learning.

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

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

V. Alphabetical Index of Resources

Leadership Role in Improving Safety
Leading a Culture of Safety: A Blueprint for Success
Living a Culture of Patient Safety Policy and Brochure
Moore Foundation Patient and Family Engagement Survey
Multifaceted Program Increases Reporting of Potential Errors, Leads to Action Plans To Enhance Safety
Nursing 2015 Just Culture Toolkit
Outcome Engenuity
Partnering To Heal: Teaming-Up Against Healthcare-Associated Infections
Patient Safety and the "Just Culture"
Patient Safety Initiative: Hospital Executive and Physician Leadership Strategies
Patient Safety Primer: Checklists
Patient Safety Primer: Culture of Safety
Patient Safety Primer: Debriefing for Clinical Learning
Patient Safety Primer: Medication Errors and Adverse Drug Events
Patient Safety Primer: Missed Nursing Care
Patient Safety Primer: Reporting Patient Safety Events
Patient Safety Self-Assessment Tool
Patient Safety Workshop – Learning From Error
Pennsylvania Patient Safety Advisory (Vol.7, Suppl. 2)
Plan-Do-Study-Act (PDSA) Steps and Worksheet
Provide Feedback to Front-Line Staff
Raising and Responding to Concerns
RCA2: Improving Root Cause Analyses and Actions To Prevent Harm
Root Cause Analysis in Health Care: Tools and Techniques
Safety Huddle Results Collection Tool
"Same Page" Transitional Care Resources for Patients and Care Partners
SBAR Tool: Situation-Background-Assessment-Recommendation
Shining a Light: Safer Health Care Through Transparency
A Slap on the Hand
TeamSTEPPS® — Team Strategies and Tools to Enhance Performance and Patient Safety
A "Ticket to Ride" Protects Patients Off the Unit
Toolkit for Using the AHRQ Quality Indicators™
Transforming Care at the Bedside
VA National Center for Patient Safety
WHO Multi-Professional Patient Safety Curriculum Guide
Why Not the Best?
WIHI: How To Speak Up for Safety
Will It Work Here?: A Decisionmaker's Guide to Adopting Innovations