

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

I. Purpose

This document provides a list of references to websites and other publicly available practical resources that 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 composite measures assessed in the Agency for Healthcare Research and Quality (AHRQ) [Hospital Survey on Patient Safety Culture](#), followed by general resources.

For easy access to the resources, keep the file open rather than printing it in hard copy 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

Resources by Composite.....	1
Composite 1. Teamwork Within Units.....	1
Composites 2 and 3. Supervisor/Manager Expectations and Actions Promoting Patient Safety and Management Support for Patient Safety.....	2
Composite 4. Organizational Learning — Continuous Improvement.....	4
Composite 5. Feedback and Communication About Error	6
Composite 6. Communication Openness.....	7
Composite 7. Frequency of Events Reported	7
Composite 8. Teamwork Across Units	9
Composite 9. Staffing.....	9
Composite 10. Handoffs and Transitions.....	10
Composite 11. Nonpunitive Response to Error	12
Composite 12: Overall Perceptions of Patient Safety and General Resources	15

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. Note that some resources are duplicated (and cross-referenced) since they are applicable to more than one composite.

Composite 1. Teamwork Within Units

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

<http://www.ahrq.gov/professionals/education/curriculum-tools/cusptoolkit/>

The Comprehensive Unit-based Safety Program (CUSP) 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. The Core CUSP 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 you step by step through the module, presentation slides, tools, and videos.

2. 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

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

<http://teamstepps.ahrq.gov/>

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

- A powerful solution to improving patient safety within your 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 your 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.

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

1. A Framework for Safe, Reliable, and Effective Care

<http://www.ihl.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.

2. Conduct Patient Safety Leadership WalkRounds™

<http://www.ihl.org/resources/Pages/Changes/ConductPatientSafetyLeadershipWalkRounds.aspx>
<http://www.ihl.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 own organization by making regular rounds for the sole purpose of discussing safety with the 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.

3. Framework for Effective Board Governance of Health System Quality

<http://www.ihl.org/resources/Pages/IHIWhitePapers/Framework-Effective-Board-Governance-Health-System-Quality.aspx> (requires free account setup and login)

The IHI Lucian Leape Institute’s 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.

4. 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 the gap in knowledge and resources by providing chief executive officers and other healthcare leaders with a useful tool for assessing and advancing their organization's culture of safety. 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.

5. 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 get a huddle program started. Appendixes include safety huddle process maps, templates, and tools.

6. 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.

7. 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. This 39-page toolkit, developed by the Joint Commission Resources Hospital Engagement Network team, as part of the national Partnership for Patients initiative, includes concise synopsis of activities that help leaders and medical staff members activate their support for patient safety.

Cross-references to other resources in this document:

- Composite 11, Nonpunitive Response to Error, #2, [Leadership Response to a Sentinel Event: Respectful, Effective Crisis Management](#)

Composite 4. Organizational Learning — Continuous Improvement

1. AHRQ Quality Indicators™ Toolkit for Hospitals

<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.

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

3. Improvement Capability Self-Assessment Tool

<http://www.ihl.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

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 present within the hospital system can lead to error. It aims to provide all healthcare workers and managers with an 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 there should be greater emphasis on patient safety in hospitals; 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.ih.org/resources/Pages/HowtoImprove/ScienceofImprovementTestingChanges.aspx>

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

(both pages require 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. 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 healthcare organization.

Composite 5. Feedback and 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 patient harm. The CANDOR toolkit contains eight modules, each containing 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.ihl.org/resources/Pages/Changes/ProvideFeedbacktoFrontLineStaff.aspx> (requires free account setup and login)

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 IHI web page identifies tips and tools for how to communicate feedback.

3. Shining a Light: Safer Health Care Through Transparency

<http://www.ihl.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 of the domains.

Cross-references to resources already described:

- Composites 2 and 3. Supervisor/Manager Expectations and Actions Promoting Patient Safety and Management Support for Patient Safety, #2, [Conduct Patient Safety Leadership WalkRounds™](#)
- Composites 2 and 3. Supervisor/Manager Expectations and Actions Promoting Patient Safety and Management Support for Patient Safety, #5, [Safety Briefings and Safety Huddles](#)

Composite 6. Communication Openness

1. WIHI: How To Speak Up for Safety

<http://www.ihl.org/resources/Pages/AudioandVideo/WIHI-Speak-Up-For-Safety.aspx>

(requires free account setup and login)

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.

2. 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 a 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.

Cross-references to resources already described:

- Composite 1. Teamwork Within Units, #2, [Pennsylvania Patient Safety Advisory](#)

Composite 7. Frequency of Events Reported

1. 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.

2. 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>

While experts consider near-misses to be unmatched predictors of medical error, research shows they are markedly underreported. This toolkit will provide you with a host of materials to run your own Good Catch Campaign to increase reporting of near-misses. There is also a case study of 45 hospitals that ran the same campaign and increased their near-miss reporting by 47 percent.

3. 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.

4. 6 Near Miss Reporting Form Examples

<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.

5. 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.

Composite 8. 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 AHRQ guide 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, #2, [Pennsylvania Patient Safety Advisory](#)
- Composite 1. Teamwork Within Units, #3, [TeamSTEPPS® – Team Strategies and Tools to Enhance Performance and Patient Safety](#)
- Composite 10. Handoffs & Transitions, #5, [SBAR Tool: Situation-Background-Assessment-Recommendation](#)

Composite 9. Staffing

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 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.

5. Transforming Care at the Bedside

<http://www.ihf.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 the lessons from the phases and results from the program.

Composite 10. Handoffs and Transitions

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 botched 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. 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.

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

<http://www.ihl.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 an additional layer of safety by enabling the patient to communicate potential safety concerns.

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

<http://www.ihl.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 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 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 that are designed to be useful to patients, care partners, and the healthcare team.

5. SBAR Tool: Situation-Background-Assessment-Recommendation

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

<http://www.ihl.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.

6. 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 resources already described:

- Composites 2 and 3. Supervisor/Manager Expectations and Actions Promoting Patient Safety and Management Support for Patient Safety, #5, [Safety Briefings and Safety Huddles](#)

Composite 11. Nonpunitive Response to Error

1. Incident Decision Tree

<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 has 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.ihl.org/resources/Pages/Tools/LeadershipResponseSentinelEventEffectiveCrisisMgmt.aspx> (requires free account setup and login)

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

3. Just Culture

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.

4. 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*, that was developed by its Culture of Safety Subcommittee, signed by the president, and mailed to all coworker homes. The brochure reinforces the nonpunitive reporting policy and encourages all coworkers to report errors.

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”).

6. 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 7. Frequency of Events Reported, #1, [Developing a Reporting Culture: Learning From Close Calls and Hazardous Conditions](#)
- Composite 7. Frequency of Events Reported, # 3, [Multifaceted Program Increases Reporting of Potential Errors, Leads to Action Plans To Enhance Safety](#)
- Composite 10. Handoffs & Transitions, #5, [SBAR Tool: Situation-Background-Assessment-Recommendation](#)

Composite 12: Overall Perceptions of Patient Safety and General Resources

1. Appoint a Safety Champion for Every Unit

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

(requires free account setup and login)

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.

2. 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, which is 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.

3. 10 Core Patient Safety Topics

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

The American Society for Healthcare Risk Management has provided important patient safety tips and information about 10 Core Patient Safety Topics in alignment with the American Hospital Association/Health Research & Educational Trust Hospital Engagement Network.

4. 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.

5. Framework for Improving Joy in Work

<http://www.ihl.org/resources/Pages/IHIWhitePapers/Framework-Improving-Joy-in-Work.aspx>

(requires free account setup and login)

This white paper from IHI 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.

6. 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.

7. 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, the goal being to ensure 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 problem.

8. 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.

9. Patient Safety Self-Assessment Tool

<http://www.ihl.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 to find areas for improvement.

10. ISMP Medication Safety Resources

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

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 URL provides ISMP's Targeted Medication Safety Best Practices for Hospitals, which were 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.

11. 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.

12. 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.

13. CAHPS® Improvement Guide

<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 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.

14. 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. 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.

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

<https://www.ahrq.gov/professionals/systems/hospital/engagingfamilies/index.html>

Research shows that when patients are engaged in their healthcare, it 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.

16. 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, HRET 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.

17. 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.

18. 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). AHRQ'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.

19. 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.

20. 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 the teaching of patient safety in universities and schools in the fields of dentistry, medicine, midwifery, nursing, and pharmacy. It 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. There are 11 patient safety topics, each designed to feature a variety of ideas and methods for patient safety learning.

21. 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

[5 Staffing Strategies for Engaged Nurses and Better Patient Outcomes](#)

[6 Near Miss Reporting Form Examples](#)

[10 Core Patient Safety Topics](#)

[10 Patient Handoff Communication Tools](#)

[2019 National Patient Safety Goals Hospital Program](#)

[Acuity-Adjusted Staffing: A Proven Strategy To Optimize Patient Care](#)

[AHRQ Comprehensive Unit-based Safety Program \(CUSP\)](#)

[AHRQ Impact Case Studies](#)

[AHRQ Patient Safety Education and Training Catalog](#)

[AHRQ Quality Indicators™ Toolkit for Hospitals](#)

[Appoint a Safety Champion for Every Unit](#)

[CAHPS® Improvement Guide](#)

[Clinical Nurse Leader Tool Kit](#)

[Common Cause Analysis: Focus on Institutional Change](#)

[Communication and Optimal Resolution \(CANDOR\) Toolkit](#)

[Conduct Patient Safety Leadership WalkRounds™](#)

[Department of Defense Patient Safety Program](#)

[Department of Veterans Affairs National Center for Patient Safety –Root Cause Analysis](#)

[Developing a Reporting Culture: Learning From Close Calls and Hazardous Conditions](#)

[Fall Prevention in Hospitals Training Program](#)

[Framework for Effective Board Governance of Health System Quality](#)

[Framework for Improving Joy in Work](#)

[Framework for Safe, Reliable, and Effective Care](#)

[Good Catch/Near Miss Campaign Toolkit](#)

[Guide to Patient and Family Engagement in Hospital Quality and Safety](#)

[Guide to Safety Huddles](#)

[Hand Hygiene in Healthcare Settings](#)

[I-PASS Handoff Bundle](#)

[Improvement Capability Self-Assessment Tool](#)

[Improving Patient Flow and Reducing Emergency Department Crowding: A Guide for Hospitals](#)

[Incident Decision Tree](#)

[ISHAPED Patient-Centered Approach to Nurse Shift Change Bedside Report](#)

[ISMP Medication Safety Resources](#)

[Just Culture](#)

[Leadership Response to a Sentinel Event: Respectful, Effective Crisis Management](#)

[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: Medication Errors](#)
[Patient Safety Primer: Missed Nursing Care](#)
[Patient Safety Primer: Voluntary Patient Safety Event Reporting \(Incident Reporting\)](#)
[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](#)
[TeamSTEPPS® — Team Strategies and Tools to Enhance Performance and Patient Safety](#)
[“Ticket to Ride” Protects Patients Off the Unit](#)
[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](#)