Improving Patient Safety in Nursing Homes: A Resource List for Users of the AHRQ Nursing Home Survey on Patient Safety Culture

I. Purpose

This document provides a list of references to websites and other publicly available practical resources nursing homes 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 nursing homes 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™) Nursing Home composite measures assessed in the Agency for Healthcare Research and Quality (AHRQ) Nursing Home 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.

Prepared by:

Westat under contract number HHSP233201500026I/HHSP23337004T for the Agency for Healthcare Research and Quality

Updated January 2019

III. Contents

IV. Resources by Composite

The following resources are organized according to the relevant AHRQ Nursing Home 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. Overall Perceptions of Resident Safety

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

   This evidence report presents practices relevant to improving patient safety, focusing on hospital care, nursing homes, ambulatory care, and patient self-management. It defines patient safety practices, provides a critical appraisal of the evidence, rates the practices, and identifies opportunities for future research.

2. **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 to find areas for improvement.

3. **Patient Safety Primer: Safety Culture**
   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 for more information on what is new in safety culture.

Composite 2. Feedback and Communication About Incidents

1. **Provide Feedback to Frontline 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 Institute for Healthcare Improvement web page identifies tips and tools for providing feedback.

2. **Safety Briefings and Safety Huddles**

   Two resources are available for conducting safety briefing 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.

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 recommends ways 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.

Composites 3 and 4. Supervisor Expectations and Actions Promoting Resident Safety and Management Support for Resident 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 (requires 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 the staff. These Institute for Healthcare Improvement (IHI) website links discuss the benefits of

management making regular rounds, gives tips for doing the rounds, and links to resources. These rounds are especially effective in conjunction with safety briefings.

2. **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 a 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.

3. **Partnership To Improve Dementia Care in Nursing Homes: State Coalition Provider Question Worksheet**
   https://www.nhqualitycampaign.org/files/Partnership_Provider_Assessment_Form.pdf

   This provider self-assessment contains a list of questions for direct caregivers and nursing home leadership to assist facilities in assessing their approach to dementia care.

Cross-references to resources already described:

- Composite 2. Feedback and Communication About Incidents, #2, Safety Briefings and Safety Huddles

Composite 5. Organizational Learning

1. **Guide to Implementing Quality Improvement Principles**
   https://www.ruralcenter.org/resource-library/guide-to-implementing-quality-improvement-principles

   This guide provides concrete tools and ideas that leaders can use to implement quality improvement in their nursing homes. The sections of this guide will explain general quality improvement principles followed by strategies for implementing quality improvement principles in your daily work.

2. **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 (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.

3. **National Nursing Home Quality Care Collaborative: Change Package**
   http://cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/Downloads/NNHQCC-Package.pdf

   This change package is intended for nursing homes participating in the National Nursing Home Quality Care Collaborative led by the Centers for Medicare & Medicaid Services (CMS) and the Medicare Quality Improvement Organizations (QIOs), to improve care for the millions of nursing home residents across the country. The change package is focused on the successful practices of high performing nursing homes. It was developed from a series of ten site visits to nursing homes across the country, and the themes that emerged regarding how they approached quality and carried out their work. The practices in the change package reflect how the nursing homes leaders and direct care staff at these sites shared and described their efforts. The change package is a menu of strategies, change concepts, and specific actionable items that any nursing home can choose from to begin testing for purposes of improving residents' quality of life and care.

4. **Patient- and Family-Centered Care Organizational Self-Assessment Tool**
   http://www.ihi.org/resources/Pages/Tools/PatientFamilyCenteredCareOrganizationalSelfAssessmentTool.aspx

   This self-assessment tool was developed by the Institute for Healthcare Improvement (in collaboration with the National Initiative for Children's Healthcare Quality and the Institute for Patient- and Family- Centered Care). It allows organizations to understand the range and breadth of elements of patient- and family-centered care and to assess where they are against the leading edge of practice. Use this self-assessment tool to assess how your organization is performing in relation to specific components of patient- and family-centered care, or as a basis for conversations about patient-centeredness in the organization.

5. **Quality Improvement Fundamentals Toolkit**
   http://www.ofmq.com/sites/default/files/QI_Fundamentals_508.pdf

   This toolkit was developed by the Oklahoma Foundation for Medical Quality and can be used to help identify opportunities for improvement and develop improvement processes.

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 to help decisionmakers determine whether an innovation would be a good fit or an appropriate stretch for their healthcare organization.

Composite 6. Training and Skills

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

   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 consisting of a robust collection of information 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.

2. **Applying High Reliability Principles to Infection Prevention and Control in Long Term Care**
   http://www.jointcommission.org/hripcltc.aspx

   The goal of this educational module is to introduce persons working in nursing homes and assisted living facilities to the principles of high reliability and how they can be applied to preventing infections in residents. This 50-minute e-learning tool was developed by the Joint Commission with partial funding from AHRQ. It features quizzes and a searchable database of practical resources. The free CDs and online format are available to all facilities, not only Joint Commission customers.

3. **Improving Patient Safety in Long-Term Care Facilities: Training Modules**
   http://www.ahrq.gov/professionals/systems/long-term-care/resources/facilities/ptsafety/index.html

   The Improving Patient Safety in Long-Term Care Facilities: Training Modules materials are intended for use in training frontline personnel in nursing homes and other long-term care facilities. The materials were developed for the Agency for Healthcare Research and Quality (AHRQ) under a contract to the RAND Corporation. They are organized into three modules:

   - Module 1: Detecting Change in a Resident's Condition
   - Module 2: Communicating Change in a Resident's Condition
   - Module 3: Falls Prevention and Management

4. **Try This: Best Practices in Nursing Care to Older Adults**
   http://consultgeri.org/try-this/general-assessment

   "Try This" is a series of assessment tools, developed by the Hartford Institute for Geriatric Nursing at New York University's College of Nursing, where each issue focuses on a topic specific to older adults. The content is directed to orient and encourage all nurses to understand the special needs of older adults and to use the highest standards of practice in caring for older adults.

Cross-references to other resources:

- Pressure Ulcer Reduction, #6, Pressure Ulcer Prevention: A Nursing Competency-Based Curriculum
- Pressure Ulcer Reduction, #9, Pressure Ulcer Baseline Assessment Survey for Registered Nurses and Nursing Assistants
- Composites 3 and 4. Supervisor Expectations and Actions Promoting Resident Safety and Management Support for Resident Safety, #3, Partnership To Improve Dementia Care in Nursing Homes: State Coalition Provider Question Worksheet

Composite 7. Compliance With Procedures

1. **Hand Hygiene in Outpatient Care, Home-Based Care, and Long-Term Care Facilities**
   http://www.who.int/gpsc/5may/EN_GPSC1_PSP_HH_Outpatient_care/en/index.html

   To respond to the demand from national representatives and stakeholders around the world, the World Health Organization (WHO) Clean Care is Safer Care team has launched the new WHO Guide on Hand Hygiene in Outpatient and Home-based Care and Long-term Care Facilities. The main objective of the guide is provide conceptual and practical guidance on the application of the WHO Multimodal Hand Hygiene Improvement Strategy and the My Five Moments approach in health-care settings where patients are not admitted as inpatients to a hospital.

2. **Hand Hygiene in Healthcare Settings**
   http://www.cdc.gov/handhygiene/training.html

   The Centers for Disease Control and Prevention's (CDC) 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 WHO, universities, and health departments.

3. **Long-Term Care Toolkit**
   http://www.mi-marr.org/LTC_toolkit.php

   This toolkit is designed to help healthcare providers in long-term care facilities implement the 12 Steps to Prevent Antimicrobial Resistance Among Long-Term Care Residents, a set of recommendations developed by the Centers for Disease Control and Prevention (CDC) as part of its Campaign to Prevent Antimicrobial Resistance in Healthcare Settings. The toolkit follows the CDC 12-step framework and is divided into 12 sections, one for each step in the CDC Campaign. Strategies on how to break specific links in the chain of infection are included in each step, along with practical information, protocols, policies, and tools designed to be easily customized for specific facility needs.

Composite 8. Teamwork

1. **TeamSTEPPS®—Team Strategies and Tools to Enhance Performance and Patient Safety**
   http://teamstepps.ahrq.gov/
   http://www.ahrq.gov/professionals/education/curriculum-tools/teamstepps/longtermcare/index.html

   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 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 9. Handoffs

1. **How-To Guide: Improving Transitions From the Hospital to Skilled Nursing Facilities To Reduce Avoidable Rehospitalizations**
   http://www.ihi.org/resources/Pages/Tools/HowtoGuideImprovingTransitionHospitalSNFstoReduceRehospitalizations.aspx (requires free account setup and login)

   IHI developed this guide to support teams in skilled nursing facilities (SNFs) and their community partners in code-signing and reliably implementing improved care processes to ensure that residents have a safe, effective transition into the SNF and are actively received by the SNF.

2. **"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 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.

Composite 10. Communication Openness

1. **SBAR Technique for Communication: A Situational Briefing Model**
   http://www.ihi.org/resources/Pages/Tools/SBARTechniqueforCommunicationASituationalBriefingModel.aspx (requires free account setup and login)

   The Situation-Background-Assessment-Recommendation (SBAR) 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 in preparing to communicate with a physician about a critically ill patient.

Composite 11. Nonpunitive Response to Mistakes

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. **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 systems 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.

3. **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 organizations that have effectively managed these crises.

4. **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 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.

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 "how" and "why," not "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 RCA to:

      - Identify causes and contributing factors of a sentinel event or 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 to measure and improve 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. With 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 10. Communication Openness, #1, SBAR Technique for Communication: A Situational Briefing Model

Composite 12. Staffing

1. **Consistent Assignment**
https://www.nhqualitycampaign.org/goalDetail.aspx?g=CA#tab4

Consistent assignment occurs when residents are consistently cared for by the same caregivers, thus increasing caregivers' familiarity with residents and strengthening relationships between caregivers and residents and their family members. The National Nursing Home Quality Improvement Campaign developed this tool that describes seven steps to achieving consistent assignment.

2. **Creation of Households Program in Nursing Home Improves Residents' Health Status, Reduces Staff Turnover, and Boosts Demand for Services**
https://innovations.ahrq.gov/profiles/creation-households-program-nursing-home-improves-residents-health-status-reduces-staff

This featured profile is available on AHRQ's Innovations Exchange website. Meadowlark Hills, a retirement community, renovated one of its facilities so that residents can live together in group households and become more independent. The innovator noted that the change in

approach led to improvements in residents' health, a sharp decrease in staff turnover, and a significant increase in demand for facility services, all without raising operating costs.

3. **Just In Time Toolkits: Recipes for Staffing Transformation**
   https://www.pioneernetwork.net/wp-content/uploads/2016/10/Just-In-Time-Toolkit-Staffing.pdf

   This toolkit is the Pioneer Network's comprehensive list of tools to assist nursing homes in various aspects of staffing, culture change, and quality improvement activities that are important to improving care for residents with dementia.

4. **Staff Stability**
   https://www.nhqualitycampaign.org/goalDetail.aspx?g=SS#tab4

   Most residents are more comfortable with caregivers they know. When long-term care communities achieve stable staffing, staff work in the community long enough to learn each resident's needs and preferences. A stable staff allows the community to benefit from experience and knowledge that staff gain over time, increasing the overall competence and confidence of staff, while building strong bonds between residents and caregivers. The National Nursing Home Quality Improvement Campaign developed this tool that describes seven steps to achieving staff stability.

V. General Resources

1. **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 policy makers, health systems, clinicians, academicians, and other professionals.

2. **Appoint a Safety Champion for Every Unit**
   http://www.ihi.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 web page identifies tips for appointing a safety champion.

3. **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.

4. **CAHPS® Nursing Home Surveys**
   https://cahps.ahrq.gov/surveys-guidance/nh/index.html

   The CAHPS program is a multiyear AHRQ initiative. This website provides information on the CAHPS Nursing Home Surveys, as well as links to three separate instruments: an in-person questionnaire for long-term residents, a mail questionnaire for recently discharged short-stay residents, and a questionnaire for residents' family members.

5. **Centers for Medicare & Medicaid Services (CMS): Quality, Safety & Oversight: Certification & Compliance**
   https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/NHs.html

   This page provides basic information about being certified as a Medicare or Medicaid nursing home provider and includes links to applicable laws, regulations, and compliance information. The site also has related nursing home reports, compendia, and a list of special focus facilities (i.e., nursing homes with a record of poor survey [inspection] performance on which CMS focuses extra attention) available for download.

6. **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.

7. **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.

8. **Get Connected! Toolkit: Linking Older Adults With Medication, Alcohol, and Mental Health Resources**
   http://www.wctcog.org/currentforms/Get%20Connected.pdf

   This toolkit developed by the National Council on Aging helps service providers for older adults learn more about alcohol and medication misuse and mental health problems in older adults to address these issues more effectively. It has been designed to help these service providers undertake health promotion, advance prevention messages and education, and undertake screening and referral for mental health problems and misuse of alcohol and medications. This toolkit helps providers coordinate these efforts and links organizations and the older adults they serve to other valuable community-based and national resources.

9. **Guide for Developing a Community-Based Patient Safety Advisory Council**
   http://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/final-reports/advisorycouncil/advisorycouncil.pdf

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

10. **Long-Term Care Improvement Guide**
    http://planetree.org/wp-content/uploads/2015/05/LTC%20Improvement%20Guide%20For%20Download.pdf

    This guide presents strategies for actualizing a resident-directed, relationship-centered philosophy. It supplies providers with tools, data, and practical resources so they can make informed decisions as they consider implementing culture change initiatives to deliver person-centered care.

11. **Making Your Printed Health Materials Senior Friendly**
    http://memoryworks.org/PUBS/NIA/Making%20Your%20Printed%20Health%20Materials%20Senior%20Friendly.pdf

    This tip sheet, developed by the National Institute on Aging, describes how to tailor health information when writing for older adults and when designing materials for older adults.

12. **Nursing Care Center: 2019 National Patient Safety Goals**
https://www.jointcommission.org/ncc_2017_npsgs/

The purpose of the Joint Commission Nursing Care Center National Patient Safety Goals is to improve patient safety in a nursing care center by focusing on specific goals.

13. **Nursing Home Quality Initiative**
https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/index.html?redirect=/nursinghomequalityinits/45_nhqimds30trainingmaterials.asp

The Nursing Home Quality Initiative website provides consumer and provider information regarding the quality of care in nursing homes.

14. **Official "Do Not Use" List Fact Sheet**
https://www.jointcommission.org/assets/1/18/Do_Not_Use_List_9_14_18.pdf

In 2001, The Joint Commission issued a Sentinel Event Alert on the subject of medical abbreviations, and 1 year later, its Board of Commissioners approved a National Patient Safety Goal requiring accredited organizations to develop and implement a list of abbreviations not to use. In 2004, The Joint Commission created its "do not use" list of abbreviations as part of the requirements for meeting that goal. In 2010, NPSG.02.02.01 was integrated into the Information Management standards as elements of performance 2 and 3 under IM.02.02.01.

15. **Older Adults: Designing Health Information To Meet Their Needs**
http://www.cdc.gov/healthliteracy/developmaterials/audiences/olderadults/index.html

This website provides tools and resources to help public health professionals improve their communication with older adults by focusing on health literacy issues. These resources are for all professionals and organizations that interact and communicate with older adults about health issues. These organizations include public health departments, healthcare providers and facilities, government agencies, nonprofit/community advocacy organizations, the media, and health-related industries.

16. **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.

17. **Person-Centered Care**
    https://www.nhqualitycampaign.org/goalDetail.aspx?g=PCC#tab4

    Advancing Excellence Campaign has identified best practices pertaining to person-centered care. This website contains a collection of tools, guides, and resources to help nursing homes get started.

18. **Pioneer Network Resource Library**
    https://www.pioneernetwork.net/resource-library/

    Pioneer Network is a center for all stakeholders in the field of aging and long-term care who focus on the culture of aging. This website features tools, articles, and links for providers on culture change and quality improvement in nursing homes.

19. **Quality Improvement Savings Tracker Worksheet**
    http://www.ihi.org/resources/Pages/Tools/QISavingsTrackerWorksheet.aspx (requires free account setup and login)

    The Quality Improvement Savings Tracker Worksheet may be used throughout the organization to track cost savings associated with waste reduction efforts and to adjust for annual changes. The tool enables the organization to compare expenses in the area of interest to expenses incurred the year prior and adjust for wage increases and productivity/volume changes. The organization can then use the worksheet to track any investments made with the savings accrued.

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

    The World Health Organization developed this 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 guide has two parts. Part A is a teacher's guide designed to introduce patient safety concepts to educators. It relates to building capacity for patient safety education, planning programs, and designing courses. 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 curriculum covers 11 patient safety topics, each designed to feature a variety of ideas and methods for patient safety learning.

VI. Other Relevant Resources

Falls Management/Prevention

1. **Best Practice Intervention Packages for Fall Prevention**
   http://www.homehealthquality.org/Education/Best-Practices.aspx

   The Best Practice Intervention Packages (BPIP) were designed for use by any home health agency to support efforts to reduce avoidable acute care hospitalizations. The topic of this package is falls prevention.

2. **Department of Veteran Affairs National Center for Patient Safety Falls Toolkit**
   http://www.patientsafety.va.gov/professionals/onthejob/falls.asp

   The Department of Veterans Affairs National Center for Patient Safety (NCPS) worked with the Patient Safety Center of Inquiry in Tampa, Florida, and others to develop the NCPS Falls Toolkit. The toolkit is designed to aid facilities in developing a comprehensive falls prevention program. This website contains links to the falls notebook, media tools, and additional resources.

3. **Falls Management Program**
   http://www.ahrq.gov/professionals/systems/long-term-care/resources/injuries/fallspx/index.html

   This interdisciplinary program is available from AHRQ. It is designed to assist nursing facilities in improving their fall care processes and outcomes through educational and quality improvement tools.

4. **Patient Fall Prevention and Management Protocol With Toileting Program**
   http://www.ihi.org/resources/Pages/Tools/PatientFallPreventionManagementProtocolwithToiletingProgramVAMCBayPines.aspx (requires free account setup and login)

   This tool is used to identify patients at risk for falls and to outline recommendations for the nursing management of patients at risk for falls or who have a history of falls.

5. **Primary Care Provider Fax Report and Orders**
   http://www.ahrq.gov/professionals/systems/long-term-care/resources/injuries/fallspx/fallspxmanapb10pcp.html

   This tool is used to communicate the results of a falls assessment to the physician, nurse practitioner, or physician's assistant. It includes a Fax Cover Sheet, Falls Assessment Report, and Fax Back Orders for the primary care provider to complete.

Pressure Ulcer Reduction

1. **Braden Scale for Predicting Pressure Sore Risk**
   http://www.bradenscale.com/images/bradenscale.pdf

   This rating scale for nurses and other healthcare providers predicts a patient's level of risk for developing pressure ulcers. The scale is composed of six subscales that measure functional capabilities of the patient that contribute to either higher intensity and duration of pressure or lower tissue tolerance for pressure.

2. **Daily Skin Care Flow Sheet**
   http://www.ihi.org/resources/Pages/Tools/DailySkinCareFlowSheet.aspx (requires free account setup and login)

   This tool was developed by the Yuma Regional Medical Center and is used by nurses to help identify the interventions needed for those patients with an identified deficit in any or all of the Braden subscales.

3. **How-To Guide: Prevent Pressure Ulcers**
   http://www.ihi.org/resources/Pages/Tools/HowtoGuidePreventPressureUlcers.aspx (requires free account setup and login)

   This guide was developed by the Institute for Healthcare Improvement and describes key evidence-based care components for preventing pressure ulcers, describes how to implement these interventions, and recommends measures to gauge improvement. The guide was initially developed as part of IHI's 5 Million Lives Campaign.

4. **AHRQ's Safety Program for Nursing Homes: On-Time Prevention**
   http://www.ahrq.gov/professionals/systems/long-term-care/resources/ontime/index.html

   AHRQ launched a program to help frontline nursing home staff reduce the occurrence of in-house pressure ulcers, providing residents with more efficient, effective, and patient-centered care. The On-Time Quality Improvement for Long-Term Care program is an innovative program designed to improve day-to-day practice in nursing homes, improve and redesign workflow, enrich work culture, and reduce pressure ulcers. This website contains program materials, a video, and readiness and health information technology assessment tools available for download.

5. **Pressure Ulcer Prevention Points**
   http://www.ihi.org/resources/Pages/Tools/PressureUlcerPreventionPoints.aspx (requires free account setup and login)

   This tool was developed by the National Pressure Ulcer Advisory Panel. This tool provides a detailed description of pressure ulcer prevention points, with references to literature and other resources.

6. **Pressure Ulcer Prevention: A Nursing Competency-Based Curriculum**
   http://www.ihi.org/resources/Pages/Tools/PressureUlcerPreventionAnNursingCompetencybasedCurriculum.aspx (requires free account setup and login)

   This training was developed by the National Pressure Ulcer Advisory Panel, which provides this sample curriculum to prepare registered nurses with the minimum competencies for pressure ulcer prevention.

7. **Preventing Pressure Ulcers Turn Clock Tool**
   http://www.ihi.org/resources/Pages/Tools/PreventingPressureUlcersTurnClockTool.aspx
   (requires free account setup and login)

   The turn clock tool is posted to alert staff that this patient has been identified as being at risk for pressure ulcers. It serves as an important reminder to reposition the patient every 2 hours, a key component of care for at-risk patients.

8. **Skin Care Facts: Pressure Ulcer Prevention**
   http://www.ihi.org/resources/Pages/Tools/SkinCareFactsPressureUlcerPrevention.aspx
   (requires free account setup and login)

   This fact sheet was developed by Iowa Health in Des Moines. This poster can be used to display important facts about skin care necessary to avoid pressure ulcers.

9. **Pressure Ulcer Baseline Assessment Survey for Registered Nurses and Nursing Assistants**
   http://www.ihi.org/resources/Pages/Tools/PressureUlcerBaselineAssessmentSurveyforRegisteredNursesandNursingAssistants.aspx (requires free account setup and login)

   This self-assessment tool can be used by nurses to determine their knowledge of how to prevent and care for pressure ulcers.

Pain Management

1. **Enhancing the Management of Neuropathic Pain in the Long-Term Care Setting**
   http://achlpicme.org/ltc/CMEInfo.aspx

   This toolkit, developed by the Academy for Continued Healthcare Learning, provides strategies and templates to help long-term care facilities and their clinicians implement a performance improvement project. The goal of this project is to help clinicians accurately and appropriately manage residents with neuropathic or persistent pain.

VII. Alphabetical Index of Resources

Nursing 2015 Just Culture Toolkit
Nursing Care Center: 2019 National Patient Safety Goals
Nursing Home Quality Initiative
Official "Do Not Use" List Fact Sheet
Older Adults: Designing Health Information To Meet Their Needs
Outcome Engenuity
Partnership To Improve Dementia Care in Nursing Homes: State Coalition Provider Question Worksheet
Patient- and Family-Centered Care Organizational Self-Assessment Tool
Patient Fall Prevention and Management Protocol With Toileting Program
Patient Safety and the "Just Culture"
Patient Safety Primer: Medication Errors
Patient Safety Primer: Safety Culture
Patient Safety Self-Assessment Tool
Person-Centered Care
Plan-Do-Study-Act (PDSA) Worksheet
Pioneer Network Resource Library
Pressure Ulcer Baseline Assessment Survey for Registered Nurses and Nursing Assistants
Pressure Ulcer Prevention: A Nursing Competency-Based Curriculum
Pressure Ulcer Prevention Points
Preventing Pressure Ulcers Turn Clock Tool
Primary Care Provider Fax Report and Orders
Provide Feedback to Frontline Staff
Quality Improvement Fundamentals Toolkit
Quality Improvement Savings Tracker Worksheet
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 Technique for Communication: A Situational Briefing Model
Shining a Light: Safer Health Care Through Transparency
Skin Care Facts: Pressure Ulcer Prevention
Staff Stability
TeamSTEPPS®—Team Strategies and Tools to Enhance Performance and Patient Safety
Try This: Best Practices in Nursing Care to Older Adults
WHO Multi-Professional Patient Safety Curriculum Guide
Will It Work Here?: A Decisionmaker's Guide to Adopting Innovations