

Improving Patient Safety in Community Pharmacies: A Resource List for Users of the AHRQ Community Pharmacy Survey on Patient Safety Culture

I. Purpose

This document provides a list of references to websites and other publicly available, practical resources community pharmacies 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 pharmacies 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™) composite measures assessed in the Agency for Healthcare Research and Quality (AHRQ) [Community Pharmacy 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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IV. Resources by Composite

The following resources are organized according to the relevant AHRQ Community Pharmacy 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. Physical Space and Environment

1. Improve Pharmacy Workflow in 6 Steps

<https://www.pbahealth.com/improve-pharmacy-workflow/>

This web page outlines six steps to improve workflow in the pharmacy setting.

2. Institute for Safe Medication Practices (ISMP) Medication Safety Self Assessment® for Community/Ambulatory Pharmacy

<http://www.ismp.org/Survey/NewMssacap/Index.asp>

This self-assessment is a comprehensive tool designed to help healthcare providers and their staff assess the safety of medication practices in their pharmacy, identify opportunities for improvement, and compare their experience with the aggregate experiences of demographically similar community pharmacies around the Nation. It is divided into the following 10 elements:

- Patient information
- Drug information
- Communication of drug orders and other drug information
- Drug labeling, packaging, and nomenclature
- Drug standardization, storage, and distribution
- Use of devices
- Environmental factors
- Staff competency and education
- Patient education
- Quality process and risk management

Composite 2. Teamwork

1. Patient Safety Primer: Teamwork Training

<https://psnet.ahrq.gov/primers/primer/8>

Providing safe healthcare depends on highly trained individuals with disparate roles and responsibilities acting together in the best interests of the patient. AHRQ's Patient Safety Primer explains this topic further and provides links to more information on teamwork training.

2. Professional Conduct Toolkit

<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/Professional-Conduct-Toolkit>

The Military Health System (MHS) is led by the Office of the Assistant Secretary of Defense for Health Affairs under the Office of the Undersecretary of Defense for Personnel and Readiness. MHS focuses on changing how healthcare is delivered throughout the United States and the world. The Professional Conduct Toolkit is designed to help healthcare teams eliminate behaviors that undermine safe patient care and adopt the professional conduct that is a hallmark of high-performing teams.

Composite 3. Staff Training and Skills

1. AHRQ Patient Safety Education and Training Catalog

<https://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.

2. Strategies To Improve Communication Between Pharmacy Staff and Patients: Training Program for Pharmacy Staff

<http://www.ahrq.gov/professionals/quality-patient-safety/pharmhealthlit/pharmlit/pharmtrain.html>

This training program is designed to introduce pharmacists to the problem of low health literacy in patient populations and to identify the implications of this problem for the delivery of healthcare services. The program also explains techniques that pharmacy staff members can use to improve communication with patients who may have limited health literacy skills.

Composite 4. Communication Openness

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

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

<http://www.ihi.org/resources/Pages/Tools/SBARTrainingScenariosandCompetencyAssessment.aspx> (both pages require 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 the Institute for Healthcare Improvement (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.

Composite 5. Patient Counseling

1. AHRQ Pharmacy Health Literacy Center

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

AHRQ Pharmacy Health Literacy Center provides pharmacists with recently released health literacy tools, curricular modules for pharmacy faculty, and resources for pharmacists interested in understanding more about health literacy.

2. Getting Your MTM Business Started

<https://www.pharmacist.com/getting-your-mtm-business-started>

From the building blocks of a medication therapy management (MTM) business model to details of service implementation, the American Pharmacists Association outlines tools to help pharmacists implement MTM services in their pharmacies.

3. Patient Outreach Tools

<http://www.pharmacist.com/tools-patient-outreach>

The American Pharmacists Association features a number of patient outreach tools that include information on national campaigns and initiatives to help pharmacies educate patients on important topics such as disposal of medications, poison control, diabetes, and physical activity.

4. PROTECT Initiative: Advancing Children’s Medication Safety

http://www.cdc.gov/medicationsafety/protect/protect_initiative.html

The PROTECT Initiative is an innovative collaboration bringing together public health agencies, private sector companies, professional organizations, consumer/patient advocates, and academic experts to develop strategies to keep children safe from unintentional medication overdoses. Medication overdoses can lead to harm, sometimes requiring emergency treatment or hospitalization and are a significant public health problem. Over-the-counter and prescription medications are commonly used for people of all ages. This frequency of use increases the potential for unintentional overdoses. Children are especially vulnerable to unintentional overdoses, most of which can be prevented.

5. Team Up. Pressure Down.

https://millionhearts.hhs.gov/files/BP_Journal.pdf

Team Up. Pressure Down is a nationwide program to lower blood pressure and prevent hypertension through patient-pharmacist engagement. The videos and resources can help patients, pharmacists, and healthcare providers better understand high blood pressure and the steps they can take to prevent or treat it. Team Up. Pressure Down was developed through the Million Hearts® Initiative sponsored by the U.S. Department of Health and Human Services.

6. Patient Education Materials Assessment Tool (PEMAT) and User's Guide

<http://www.ahrq.gov/professionals/prevention-chronic-care/improve/self-mgmt/pemat/index.html>

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

Cross-reference to resource already described:

- Composite 3. Staff Training and Skills, #2, [Strategies To Improve Communication Between Pharmacy Staff and Patients: Training Program for Pharmacy Staff](#)

Composite 6. Staffing, Work Pressure, and Pace

1. Beating Behind-the-Counter Job Stress

<http://www.pharmacytimes.com/publications/issue/2010/October2010/BeatingJobStress-1010>

Heavy workloads and long hours make stress management a critical skill for pharmacists. With a basic knowledge of coping strategies, pharmacists can overcome stress to achieve their personal best. This feature in *Pharmacy Times* defines stress in the pharmacy and identifies possible solutions for handling the stress.

2. Deflect Distractions and Intercept Interruptions

<http://www.pharmacist.com/node/206033>

The American Pharmacists Association notes the Institute for Safe Medication Practices error alert on interruptions and distractions, and discusses the effects of interruptions and distractions, their sources, and strategies to help decrease distractions.

Composite 7. Communication About Prescriptions Across Shifts

Cross-reference to resource already described:

- Composite 4. Communication Openness, #1, [SBAR Tool: Situation-Background-Assessment-Recommendation](#)

Composite 8. Communication About Mistakes

1. Provide Feedback to Front-Line Staff

<http://www.ihl.org/resources/Pages/Changes/ProvideFeedbacktoFrontLineStaff.aspx> (requires free account setup and login)

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

2. 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.

Composite 9. 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 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.

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. 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.

Composite 10. Organizational Learning—Continuous Improvement

1. 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 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. 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”).

2. Improving Medication Safety in Community Pharmacy: Assessing Risk and Opportunities for Change

<http://www.ismp.org/communityRx/aroc/> (requires email address for access)

This manual is designed to help community pharmacy personnel identify potential medication safety risks and prevent errors. Pharmacists can use the materials and tools in this manual to pinpoint specific areas of weakness in their medication delivery systems and to provide a starting point for successful organizational improvements.

The goals of this manual are to:

- Raise awareness of error-prone processes in the medication delivery system.
- Build awareness of risk-identification opportunities in the community pharmacy setting.
- Maximize the appropriate application of system strategies to reduce organizational risk.

3. 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.

4. **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.

Cross-reference to resource already described:

- Composite 9. Response to Mistakes, #2, [Incident Decision Tree](#)

Composite 11. Overall Perceptions of Patient Safety

1. **Assessing Barcode Verification System Readiness in Community Pharmacies**

<https://www.ismp.org/sites/default/files/attachments/2018-10/BarcodeAssessment.pdf>

Developed by the Institute for Safe Medication Practices and funded by AHRQ, this assessment tool can be used to help community pharmacies prepare for future implementation of a barcode product verification system. This tool can help pharmacy leaders and staff evaluate their current workflow, standard operating procedures, and technology to identify what needs to be accomplished before implementing a barcode product verification system.

2. **Facts About the Official “Do Not Use” List**

http://www.jointcommission.org/facts_about_do_not_use_list/

In 2001, The Joint Commission issued a Sentinel Event Alert on the subject of medical abbreviations, and just one 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.

3. **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.

Cross-reference to resource already described:

- Composite 1. Physical Space and Environment, #2, [Institute for Safe Medication Practices \(ISMP\) Medication Safety Self Assessment® for Community/Ambulatory Pharmacy](#)

V. General Resources

1. AHRQ Impact Case Studies

https://www.ahrq.gov/news/newsroom/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.

2. CAHPS® Improvement Guide

<https://www.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.

3. 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.

4. 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 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.

5. ISMP’s List of Confused Drug Names

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

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

6. Leading a Culture of Safety: A Blueprint for Success

<http://www.ihl.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.

7. 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.

8. A Toolset for E-Prescribing Implementation in Independent Pharmacies

<http://healthit.ahrq.gov/health-it-tools-and-resources/implementation-toolsets-e-prescribing/toolset-e-prescribing-0>

This toolset is designed to assist pharmacies in adopting e-prescribing. It consists of seven chapters that provide guidance on various implementation topics and tools that can facilitate the implementation process.

9. 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 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. Alphabetical Index of Resources

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