

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

Last updated April 2010

Purpose

This document contains references to Web sites that provide practical resources hospitals can use to implement changes to improve patient safety culture and patient safety. This resource list is not exhaustive, but is provided to give initial guidance to hospitals looking for information about patient safety initiatives. This document will be updated periodically.

How to Use This Resource List

General resources are listed first, in alphabetical order, followed by resources organized by the dimensions assessed in the Agency for Healthcare Research and Quality (AHRQ) *Hospital Survey on Patient Safety Culture* (available at <http://www.ahrq.gov/qual/patientsafetyculture>).

For easy access to the resources, keep the file open rather than printing it in hard copy because the Web site URLs are hyperlinked and cross-referenced resources are bookmarked within the document.

NOTE: The resources included in this document do not constitute an endorsement by the U.S. Department of Health and Human Services (HHS), the Agency for Healthcare Research and Quality (AHRQ), or any of their employees. HHS does not attest to the accuracy of information provided by linked sites.

Suggestions for tools you would like added to the list, questions about the survey, or requests for assistance can be addressed to: SafetyCultureSurveys@ahrq.hhs.gov.

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General Resources

1. **10 Patient Safety Tips for Hospitals**

<http://www.ahrq.gov/qual/10tips.pdf>

Medical errors (or adverse events) can occur at many points in the health care system, particularly in hospitals. These tips for hospitals are from studies by the Agency for Healthcare Research and Quality (AHRQ), which has funded more than 100 patient safety projects since 2001. Many findings from AHRQ research can be put into practice in hospitals by following these 10 practical tips.

2. **2010 National Patient Safety Goals Critical Access Hospital Program**

<http://www.jointcommission.org/patientsafety/nationalpatientsafetygoals/>

The purpose of The Joint Commission National Patient Safety Goals Critical Access Hospital Program is to improve patient safety in critical access hospitals through focusing on specific goals. This Web site contains a link to the latest goals which includes improvements emanating from the Standards Improvement Initiative. In addition, there is information regarding the new numbering system and minor language changes for consistency.

3. **2010 National Patient Safety Goals Hospital Program**

<http://www.jointcommission.org/patientsafety/nationalpatientsafetygoals/>

The purpose of The Joint Commission National Patient Safety Goals Hospital Program is to improve patient safety in hospitals through focusing on specific goals. This Web site contains a link to the latest goals which includes improvements emanating from the Standards Improvement Initiative. In addition, there is information regarding the new numbering system and minor language changes for consistency.

4. **30 Safe Practices for Better Health Care Fact Sheet**

<http://innovations.ahrq.gov/content.aspx?id=765>

This fact sheet is featured on the Agency for Healthcare Research and Quality's Health Care Innovations Exchange. The National Quality Forum has identified 30 safe practices that, evidence shows, can work to reduce or prevent adverse events and medication errors. These practices can be universally adopted by all health care settings to reduce the risk of harm to patients. This tool also provides background information about the National Quality Forum, as well as links to a report providing more detailed information about the 30 Safe Practices.

5. **AHRQ Health Care Innovations Exchange**

<http://www.innovations.ahrq.gov/>

The U.S. Agency for Healthcare Research and Quality's Health Care Innovations Exchange is a comprehensive program designed to accelerate the development and adoption of innovations in health care delivery. This program supports the Agency's mission to improve the safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity of care—with a particular emphasis on reducing disparities in health care and health among racial, ethnic, and socioeconomic groups. The Innovations Exchange has the following components:

- Searchable innovations and attempts
- Searchable QualityTools
- Learning opportunities
- Networking opportunities

6. **AHRQ Medical Errors and Patient Safety**

<http://www.ahrq.gov/qual/errorsix.htm>

The Agency for Healthcare Research and Quality (AHRQ) Medical Errors and Patient Safety Web site provides links to various resources and tools for promoting patient safety in the following categories:

- Tips for Consumers and Patients
- Background
- Communication and Teamwork
- Design and Working Conditions
- Implementation and Transformation
- Patient Safety Organizations
- Patient Safety Research and Funding Opportunities
- Tools and Techniques

7. **AHRQ Patient Safety Network**

<http://www.psnet.ahrq.gov/>

AHRQ Patient Safety Network (PSNet) is a national web-based resource featuring the latest news and essential resources on patient safety. The site offers weekly updates of patient safety literature, news, tools, and meetings ("What's New"), and a vast set of carefully annotated links to important research and other information on patient safety ("The Collection"). Supported by a robust patient safety taxonomy and web architecture, AHRQ PSNet provides powerful searching and browsing capability, as well as the ability for diverse users to customize the site around their interests (My PSNet). It also is tightly coupled with AHRQ WebM&M, the popular monthly journal that features user-submitted cases of medical errors, expert commentaries, and perspectives on patient safety.

8. **Becoming a High Reliability Organization**

<http://www.ahrq.gov/qual/hroadvice/index.html>

This document from AHRQ is written for hospital leaders interested in providing patients safer and higher quality care. It presents the thoughts, successes, and failures of hospital leaders who have used concepts of high reliability to make patient care better. High reliability concepts are tools that a growing number of hospitals use to help achieve their safety, quality, and efficiency goals. Creating a culture and processes that radically reduce system failures and effectively respond when failures do occur is the goal of high reliability thinking.

9. **CAHPS Hospital Survey**

http://www.cahps.ahrq.gov/content/products/hosp/PROD_HOSP_Intro.asp

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) program is a multi-year initiative of the Agency for Healthcare Research and Quality (AHRQ) to support the assessment of consumers' experiences with health care. This Web site provides information on the CAHPS Hospital Survey (H-CAHPS) surveys including the questionnaire and administration guidelines as well as reporting and benchmarking data.

10. **CAHPS Improvement Guide**

<http://www.cahps.ahrq.gov/QIguide/content/interventions/default.aspx>

The extensive and growing use of 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 who are responsible for measuring performance and improving the quality of services provided by health plans, medical groups, and individual physicians. Over time, this guide will be updated to include new improvement interventions and offer additional resources.

11. The Commonwealth Fund

<http://www.commonwealthfund.org/>

The Commonwealth Fund is a private foundation that aims to promote a high performing health care system that achieves better access, improved quality, and greater efficiency, particularly for society's most vulnerable, including low-income people, the uninsured, minority Americans, young children, and elderly adults. The Commonwealth Fund provides information on a variety of health care topics, free publications, and innovations and tools for improving health care.

12. Consumers Advancing Patient Safety

<http://www.patientsafety.org/>

Consumers Advancing Patient Safety (CAPS) is a consumer-led nonprofit organization aimed at providing a collective voice for individuals, families and healers who wish to prevent harm in healthcare encounters through partnership and collaboration. CAPS features a transitions toolkit (available at <http://www.patientsafety.org/page/142046/>) entitled “Taking Charge of Your Healthcare: Your Path to Being an Empowered Patient - Toolkit Introduction”.

13. Department of Defense Patient Safety Program

<http://dodpatientsafety.usuhs.mil>

The Department of Defense Patient Safety Program is a comprehensive program with the goal of establishing a culture of patient safety and quality within Military Health System (MHS). The program encourages a systems approach to create safer patient environment; engages MHS leadership; promotes collaboration across all three Services; and fosters trust, transparency, teamwork, and communication.

14. Institute for Healthcare Improvement

<http://www.ihl.org/ihl>

IHI is a reliable source of energy, knowledge, and support for a never-ending campaign to improve health care worldwide. The Institute helps accelerate change in health care by cultivating promising concepts for improving patient care and turning those ideas into action.

15. Institute for Safe Medication Practices

<http://www.ismp.org>

The Institute for Safe Medication Practices offers a wide variety of free educational materials and services on their Web site:

- Special Medication Hazard Alerts
- Searchable information on a wide variety of medication safety topics
- Answers to *Frequently Asked Questions* about medication safety
- FDA Patient Safety Videos
- *Pathways for Medication Safety Tools*
- White papers on bar-coding technology and electronic prescribing
- A monitored *Message Board* to share questions, answers, and ideas

16. The Joint Commission: Patient Safety

<http://www.jointcommission.org/PatientSafety/>

The Patient Safety pages on The Joint Commission Web site offer information on patient safety-related standards, the National Patient Safety Goals, the Speak Up™ initiatives (a national program urging patients to become active participants on their health care team), and other resources.

17. Minnesota Alliance for Patient Safety

<http://www.mnpatientsafety.org>

The Minnesota Alliance for Patient Safety (MAPS) is a partnership among the Minnesota Hospital Association, Minnesota Medical Association, Minnesota Department of Health and more than 50 other public-private health care organizations working together to improve patient safety.

18. National Center for Patient Safety

<http://www.patientsafety.gov>

The National Center for Patient Safety (NCPS) was established in 1999 to develop and nurture a culture of safety throughout the Veterans Health Administration. The primary intended audience for the public Web site is health care professionals and health care administrators.

19. National Patient Safety Foundation

<http://www.npsf.org/>

The National Patient Safety Foundation® has been diligently pursuing one mission since its founding in 1997 – to improve the safety of the healthcare system for the patients and families it serves. NPSF is unwavering in its determined and committed focus on uniting disciplines and organizations across the continuum of care, championing a collaborative, inclusive, multi-stakeholder approach.

20. National Quality Forum

<http://www.qualityforum.org/Topics/Safety.aspx>

The National Quality Forum (NQF) is a nonprofit organization that aims to improve the quality of healthcare for all Americans through fulfillment of its three-part mission:

- Setting national priorities and goals for performance improvement;
- Endorsing national consensus standards for measuring and publicly reporting on performance; and
- Promoting the attainment of national goals through education and outreach programs.

21. Partnering with Patients to Create Safe Care

http://www.ihi.org/ihi/files/Forum/2008/Handouts/DE24_PartnerPatients_Weingart.pdf

Partnering with Patient to Create Safe Care is a presentation from the IHI National Forum by representatives at Dana-Farber Cancer Institute. The presentation highlights Dana-Farber's journey in family centered care and steps necessary to advance patient and family participation in safety and quality initiatives.

22. Patient Safety in Small Rural Hospitals

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

In July of 2005, the Agency for Healthcare Research and Quality (AHRQ) awarded the University of Nebraska Medical Center a two-year Partnerships in Implementing Patient Safety (PIPS) grant. The purpose of this project was to implement the patient safety practices of voluntary medication error

reporting and organizational learning to improve the safety of medication use in small rural hospitals. This Web site provides a variety of patient safety tools that can be used with the AHRQ Hospital Survey on Patient Safety Culture (HSOPSC).

23. **Pennsylvania Patient Safety Authority**

<http://www.patientsafetyauthority.org/Pages/Default.aspx>

The Authority is charged with taking steps to reduce and eliminate medical errors by identifying problems and recommending solutions that promote patient safety in various health care settings. The Web site features issues of current patient safety articles as well as highlights patient safety initiatives and tools. You can browse by care setting, event (i.e. falls, medication errors), discipline, audience, and patient safety focus.

24. **Premier Safety Institute™**

<http://www.premierinc.com/quality-safety/tools-services/safety/index.jsp>

The Premier Safety Institute provides safety resources and tools to promote a safe healthcare delivery environment for patients, workers, and their communities.

25. **Transforming Hospitals: Designing for Safety and Quality**

<http://innovations.ahrq.gov/content.aspx?id=1943>

This DVD is featured on the Agency for Healthcare Research and Quality's Health Care Innovations Exchange Web site. It reviews the case for evidence-based hospital design and how it increases patient and staff satisfaction and safety, quality of care, and employee retention, and results in a positive return on investment.

26. **WHO Collaborating Centre for Patient Safety Solutions**

<http://www.ccforspatientsafety.org/patient-safety-solutions>

The Joint Commission, Joint Commission International, and World Health Organization host a centre for patient safety solutions. This Web site provides information about nine solutions for improving patient safety approved by the International Steering Committee. Solutions include: (1) Look-Alike, Sound-Alike Medication Names, (2) Patient Identification, (3) Communication During Patient Hand-Overs, (4) Performance of Correct Procedure at Correct Body Site, (5) Control of Concentrated Electrolyte Solutions, (6) Assuring Medication Accuracy at Transitions in Care, (7) Avoiding Catheter and Tubing Mis-Connections, (8) Single Use of Injection Devices, and (9) Improved Hand Hygiene to Prevent Health Care-Associated Infection.

27. **Why Not the Best?**

<http://whynotthebest.org/contents/>

Why Not the Best is a health care quality improvement resource from The Commonwealth Fund. Learn from other hospitals about successful strategies and tools to create safe, reliable health care processes and deliver high-quality care to patients. Case studies and tools are linked to performance measures for particular conditions or areas of care.

Resources by Dimension

The following resources are organized according to the relevant HSOPS dimensions they can help improve. Some resources are duplicated and cross-referenced because they may apply to more than one dimension.

Dimension 1. Teamwork Within Units

1. Crisis Management Simulation Course

<http://www.innovations.ahrq.gov/content.aspx?id=265>

This featured profile is available on the Agency for Healthcare Research and Quality's Health Care Innovations Exchange Web site. Crisis Resource Management (CRM) is a 7-hour course for labor and delivery (L&D) practitioners that employs various strategies of crew resource management, a safety program developed by the aviation industry, to create realistic simulations designed to facilitate improvement of teamwork and communication skills in a real L&D crisis. According to post-implementation surveys, the course is highly regarded by the vast majority of participants; surveys conducted 1 or more years after the course suggest that it produces lasting benefits, including improvements in communication, team leadership, and team performance during crises.

2. Curricula for Simulated Obstetric Emergency Response Drills & Safety (CORDS™)

<http://www.innovations.ahrq.gov/content.aspx?id=1937>

The CORDS toolkit is featured on the Agency for Healthcare Research and Quality's Health Care Innovations Exchange Web site. It was designed to use military and aviation style simulation experiences to prepare labor and delivery staff for an obstetrical emergency. The toolkit also includes information about the importance of communication and teamwork.

3. Patient Safety Primer: Teamwork Training

<http://psnet.ahrq.gov/primer.aspx?primerID=8>

Providing safe health care depends on highly trained individuals with disparate roles and responsibilities acting together in the best interests of the patient. The Agency for Healthcare Research and Quality (AHRQ) Patient Safety Network explains this topic further and provides links for more information on what's new in teamwork training.

4. Patient Safety Through Teamwork and Communication Toolkit

<http://innovations.ahrq.gov/content.aspx?id=1947>

This toolkit is featured on the Agency for Healthcare Research and Quality's Health Care Innovations Exchange Web site. It consists of an education guide and communication tools. The education guide provides a plan for the education and integration of communication and teamwork factors into clinical practice. The communication tools section provides a description for each of the following tools along with provisions for implementation:

- Multidisciplinary Rounding
- Huddles
- Rapid Response and Escalation
- Structured Communication

5. **TeamSTEPPS™ - Team Strategies and Tools to Enhance Performance and Patient Safety**
<http://teamstepps.ahrq.gov/>

Developed jointly by the Department of Defense (DoD) and the Agency for Healthcare Research and Quality (AHRQ), TeamSTEPPS™ is a resource for training healthcare providers in better teamwork practices. The training package capitalizes on DoD's years of experience in medical and nonmedical team performance and AHRQ's extensive research in the fields of patient safety and healthcare quality. Following extensive field testing in the Military Health System (MHS) and several civilian organizations, a multimedia TeamSTEPPS toolkit is now available in the public domain to civilian healthcare facilities and medical practices. Additional TeamSTEPPS tools are in development.

- “TeamSTEPPS™: Integrating Teamwork Principles into Healthcare Practice”: An article in the November/December 2006 issue of Patient Safety and Quality Healthcare
<http://www.psqh.com/novdec06/ahrq.html>
- TeamSTEPPS™ Readiness Assessment Tool
<http://teamstepps.ahrq.gov/ahrqchecklist.aspx>

Answering these questions can help your institution understand its level of readiness to initiate the TeamSTEPPS program. You may find it helpful to have a colleague review your responses or to answer the questions with a larger group (e.g., senior leaders).

- TeamSTEPPS™ Rapid Response Systems (RRS) Training Module
<http://teamstepps.ahrq.gov/abouttoolsmaterials.htm> (order information available on this Web site)

This evidence-based module will provide insight into the core concepts of teamwork as they are applied to the rapid response system (RRS). The module contains the Instructor Guide in electronic form plus training slides that include a high-quality video vignette of teamwork as it relates to RRS. This comes as a CD-ROM with the printable files (Word®, PDF, and PowerPoint®)

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

1. **Appoint a Safety Champion for Every Unit**
<http://www.ihl.org/IHI/Topics/PatientSafety/SafetyGeneral/Changes/IndividualChanges/Appoint+a+Safety+Champion+for+Every+Unit.htm>

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

2. **Conduct Patient Safety Leadership WalkRounds™**
<http://www.ihl.org/IHI/Topics/PatientSafety/SafetyGeneral/Changes/IndividualChanges/Conduct+Patient+Safety+Leadership+WalkRounds.htm>

Senior leaders can demonstrate their commitment to safety and learn about the safety issues in their own organization by making regular rounds to discuss safety issues with the frontline staff. This Institute for Healthcare Improvement (IHI) Web site discusses the benefits for management making regular rounds and

provides links to tools available for download. One specific tool created by Dr. Allan Frankel is highlighted: <http://www.wsha.org/files/82/WalkRounds1.pdf>

3. **Framework for Leadership Improvement**

<http://www.ihl.org/IHI/Topics/LeadingSystemImprovement/Leadership/EmergingContent/AFrameworkforLeadershipofImprovement.htm>

This framework, developed by the Institute for Healthcare Improvement, was built upon the concepts of “will, ideas, and execution.” It organizes leadership processes that focus the organization and senior leaders on improvement.

4. **Get Boards on Board**

<http://www.ihl.org/IHI/Programs/Campaign/BoardsonBoard.htm>

This resource from the Institute for Healthcare Improvement offers a how-to guide, presentation, tools, and resources for obtaining board support for patient safety.

5. **Leadership Guide to Patient Safety**

<http://www.patientsafetyboard.org/DesktopModules/Documents/DocumentsView.aspx?tabID=0&ItemID=31896&Mid=5204&wversion=Staging>

This Leadership Guide to Patient Safety is part of the Institute for Healthcare Improvement’s Innovation series. It shares the experience of senior leaders who have decided to address patient safety and quality as a strategic imperative within their organizations. It presents what can be done to make the dramatic changes that are necessary to ensure that patients are not harmed by the very care systems they trust will heal them.

6. **Patient Safety Rounding Toolkit**

<http://www.dana-farber.org/pat/patient-safety/patient-safety-resources/patient-rounding-toolkit.html>

The Patient Safety Rounding Toolkit is available to download from the Dana-Farber Cancer Institute. It provides resources for assessing whether an organization will benefit from patient safety rounds and for designing and implementing a patient safety rounds program.

7. **Strategies for Leadership – Patient- and Family-Centered Care**

<http://www.aha.org/aha/issues/Quality-and-Patient-Safety/strategies-patientcentered.html>

This Strategies for Leadership toolkit from the American Hospital Association (AHA) complements previous toolkits and other AHA activities that have focused on safety, effectiveness, efficiency, timeliness and equity in care. It features a video, discussion guide, and resource guide.

Dimension 4. Organizational Learning – Continuous Improvement

1. **AHRQ Health Care Innovations Exchange Learn & Network**

http://www.innovations.ahrq.gov/learn_network/listall.aspx

How do you introduce innovations to your organization? How do you encourage others to think "outside the box" and accept new ideas? Browse the Learn & Network part of this site to find advice and ideas from experts and practitioners, insights from the literature, as well as opportunities to participate in discussions and learning networks on specific topics.

2. **Decision Tree for Unsafe Acts Culpability**

<http://www.ihl.org/IHI/Topics/PatientSafety/SafetyGeneral/Tools/Decision+Tree+for+Unsafe+Acts+Culpability.htm>

The decision tree for unsafe acts culpability is a tool available for download from Institute for Healthcare Improvement (IHI)'s Web site. Use this decision tree when analyzing an error or adverse event that has occurred in your organization to help identify how human factors and systems issues contributed to the event. This decision tree is particularly helpful when working toward a non-punitive approach in your organization.

3. **Error Proofing**

<http://www.ihl.org/IHI/Topics/Improvement/ImprovementMethods/Changes/Error+Proofing.htm>

Errors occur when our actions do not agree with our intentions even though we are capable of carrying out the task. This Web site from the Institute for Healthcare Improvement (IHI) outlines error proofing. It includes links to the following topics which contain more specific information and strategies:

- Use Affordances
- Use Constraints
- Use Differentiation
- Use Reminders

4. **Institute for Healthcare Improvement: Plan-Do-Study-Act (PDSA) Worksheet (IHI Tool)**

[http://www.ihl.org/IHI/Topics/Improvement/ImprovementMethods/Tools/Plan-Do-Study-Act+\(PDSA\)+Worksheet.htm](http://www.ihl.org/IHI/Topics/Improvement/ImprovementMethods/Tools/Plan-Do-Study-Act+(PDSA)+Worksheet.htm)

The Plan-Do-Study-Act (PDSA) Worksheet is a useful tool for documenting a test of change. The PDSA cycle is shorthand for testing a change by developing a plan to test the change (Plan), carrying out the test (Do), observing and learning from the consequences (Study), and determining what modifications should be made to the test (Act).

5. **Mistake-Proofing the Design of Health Care Processes**

<http://innovations.ahrq.gov/content.aspx?id=482>

This resource is featured on the Agency for Healthcare Research and Quality's Health Care Innovations Exchange. Mistake-Proofing the Design of Health Care Processes is a synthesis of practical examples of health care on the use of process or design features to prevent medical errors or the negative impact of errors. It contains over 150 examples of mistake-proofing that can be applied in health care—and in many cases relatively inexpensively. In Mistake-Proofing the Design of Health Care Processes, risk managers and chief medical officers will benefit from common-sense approaches to reducing risk and litigation, and organizations will find the groundwork for a successful program that fosters innovation and creativity as they address their patient safety concerns and approaches.

6. **Patient Safety Primer: Root Cause Analysis**
<http://www.psnet.ahrq.gov/primer.aspx?primerID=10>

Root cause analysis (RCA) is a structured method used to analyze adverse events. Initially developed to analyze industrial accidents, RCA is now widely deployed as an error analysis tool in health care. The Agency for Healthcare Research and Quality (AHRQ) Patient Safety Network explains this topic further and provides links for more information on what's new in RCA.

7. **VA National Center for Patient Safety – NCPS Root Cause Analysis Tool**
<http://www.va.gov/ncps/CogAids/RCA/index.html>

Since 1999, NCPS has developed tools, training and software to facilitate patient safety and Root Cause Analysis (RCA) investigations. This guide functions as a cognitive aid to help teams in developing a chronological event flow diagram (an understanding of what occurred) along with a cause and effect diagram (why the event occurred). RCA teams have found this book an effective aid with these sometimes nettlesome activities.

8. **Voluntary System to Report and Analyze Nursing Errors Leads to Patient Safety Improvements**
<http://www.innovations.ahrq.gov/content.aspx?id=2246>

This featured profile is available on the Agency for Healthcare Research and Quality's Health Care Innovations Exchange Web site. The Healthcare Alliance Safety Partnership is a 3-year quality improvement pilot project involving a board of nursing and three hospital systems in developing a voluntary, nonpunitive system for reporting, investigating, and analyzing nursing errors. During the 3 years of reporting, nurses reported incidents to the partnership; then, nurse analysts performed an extensive investigation and worked with a multidisciplinary committee to make prescriptive recommendations to the nurse and the institution regarding organizational, individual, and technical improvements that could be made to reduce the chance of recurrence. Though numbers of participating nurses were limited, the changes made by the hospital systems helped to address a wide variety of safety problems that were directly under the control of these organizations and led to the adoption of a multitude of quality improvements.

9. **Will It Work Here?: A Decisionmaker's Guide to Adopting Innovations**
<http://www.innovations.ahrq.gov/resources/InnovationAdoptionGuide.pdf>

The goal of this Guide is to promote evidence-based decisionmaking and help decisionmakers determine whether an innovation would be a good fit—or an appropriate stretch—for their health care organization.

Dimension 5. Overall Perceptions of Patient Safety

1. **Basic Patient Safety Program Resource Guide for “Getting Started”**
<http://www.innovations.ahrq.gov/content.aspx?id=383>

This resource guide is featured on the Agency for Healthcare Research and Quality's Health Care Innovations Exchange Web site. It provides tools to assist health care facilities in implementing a patient safety program. This toolkit includes the following program tools, all of which may be customized as needed:

- Generic safety plan: template
- Comprehensive medical safety program
- Quality and safety officer job description: template

- Organized assignments for accompanying patient safety plan or program
- American Society for Healthcare Risk Management: Perspective on disclosure of unanticipated outcome information
- Checklist for patient safety and Joint Commission on the Accreditation of Healthcare Organizations standards

2. **Culture & Safety**

<http://www.cultureandsafety.com/>

This webpage hosts a PowerPoint presentation by Robert M. Bell, MD., Ph.C on culture and safety in medicine as well as additional handouts on culture enhancers and diminishers.

3. **Improving Patient Safety in Hospitals: Turning Ideas into Action**

<http://www.med.umich.edu/patientsafetytoolkit/index.htm>

The University of Michigan Health System developed a resource for clinicians and administrative leaders responsible for strategic initiatives aimed and creating and sustaining quality of care and patient safety in hospitals. This patient safety toolkit presents ways of turning patient safety ideals into practical and achievable strategies. It includes information on the following topics: overview, safety plan, adverse events, infection prevention and control, safety culture, safety curriculum, medication safety, and disclosure.

4. **Making Health Care Safer: A Critical Analysis of Patient Safety Practices**

<http://innovations.ahrq.gov/content.aspx?id=399>

This evidence report is featured on the Agency for Healthcare Research and Quality's Health Care Innovations Exchange Web site. It 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.

5. **Patient Safety Primer: Safety Culture**

<http://psnet.ahrq.gov/primer.aspx?primerID=5>

The concept of safety culture originated outside health care, in studies of high reliability organizations, organizations that consistently minimize adverse events despite carrying out intrinsically complex and hazardous work. High reliability organizations maintain a commitment to safety at all levels, from frontline providers to managers and executives. This commitment establishes a "culture of safety". The Agency for Healthcare Research and Quality (AHRQ) Patient Safety Network explains this topic further and provides links for more information on what's new in safety culture.

6. **Studer Group Toolkit: Patient Safety**

<http://innovations.ahrq.gov/content.aspx?id=2592>

This toolkit is featured on the Agency for Healthcare Research and Quality's Health Care Innovations Exchange Web site. It provides health care leaders and frontline staff specific tactics they can immediately put into action to improve patient safety outcomes. By routinizing specific behaviors, organizations can improve patient safety without purchasing new equipment, adding staff, or spending additional time to put them into practice. The actions are divided into eight sections, each of which has been identified as a priority area for health care organizations to address as they seek to provide safer care.

7. **The Transforming Care at the Bedside Toolkit**

<http://innovations.ahrq.gov/content.aspx?id=2327>

This toolkit is featured on the Agency for Healthcare Research and Quality's Health Care Innovations Exchange Web site. It provides information for hospital units interested in adopting the "Transforming Care at the Bedside" (TCAB) model of nurse-initiated quality improvements. TCAB is a national program developed and managed by the Robert Wood Johnson Foundation and the Institute for Healthcare Improvement.

Dimension 6. Feedback & Communication about Error

1. **Conduct Safety Briefings**

<http://www.ihl.org/IHI/Topics/PatientSafety/SafetyGeneral/Changes/IndividualChanges/Conduct+Safety+Briefings.htm>

Safety briefings in patient care units are tools to increase safety awareness among front-line staff and foster a culture of safety. This Institute for Healthcare Web site (IHI) identifies tips and tools for conducting safety briefings.

2. **Provide Feedback to Frontline Staff**

<http://www.ihl.org/IHI/Topics/PatientSafety/SafetyGeneral/Changes/IndividualChanges/Provide+Feedback+to+Front-Line+Staff.htm>

Feedback to the front-line staff is a critical component of demonstrating a commitment to safety and ensuring that staff members continue to report safety issues. This Institute for Healthcare (IHI) Web site identifies tips and tools for how to communicate feedback.

Dimension 7. Communication Openness

1. **Arizona Hospital and Healthcare Association SBAR Communication**

http://www.azhha.org/patient_safety/sbar.aspx

This SBAR (Situation-Background-Assessment-Recommendation) Communication toolkit, available for download through the Arizona Hospital and Healthcare Association, is designed to be a thorough guide to assist your facility through the implementation and training of SBAR communication. Items included in this tool kit are samples of SBAR documents, staff education, including practice scenarios to use SBAR, policy recommendations, and more.

2. **SBAR Technique for Communication: A Situational Briefing Model**

<http://www.ihl.org/IHI/Topics/PatientSafety/SafetyGeneral/Tools/SBARTechniqueforCommunicationASituationalBriefingModel.htm>

The SBAR (Situation-Background-Assessment-Recommendation) technique provides a framework for communication between members of the health care team about a patient's condition. When you download this tool from Institute for Healthcare Improvement (IHI), you will find two documents. The document, "SBAR report to physician about a critical situation," is a worksheet/script that a provider can use to organize information in preparation for communicating with a physician about a critically ill patient. The document, "Guidelines for Communicating with Physicians Using the SBAR Process," explains how to carry out the SBAR technique in detail.

Cross-references to resources already described:

- See Dimension 1. Teamwork Within Units, # 1 [Crisis Management Simulation Course](#)
- See Dimension 1. Teamwork Within Units, # 2 [Curricula for Simulated Obstetric Emergency Response Drills & Safety \(CORDS™\)](#)
- See Dimension 1. Teamwork Within Units, # 4 [Patient Safety Through Teamwork and Communication Toolkit](#)

Dimension 8. Frequency of Events Reported

1. **“The Good Catch” Program Increases Reporting & Leads to Action Plans to Enhance Safety**
<http://www.innovations.ahrq.gov/content.aspx?id=273>

This featured profile is available on the Agency for Healthcare Research and Quality’s Health Care Innovations Exchange Web site. The University of Texas M. D. Anderson Cancer Center implemented a multifaceted initiative, known as "The Good Catch" Program, to increase the reporting of potential errors related to medication, equipment, and patient care. Key elements of the program include (1) a change in use of terminology from negative to positive terms and phrases (e.g., from "close call" or "near miss" to "good catch"); (2) friendly, team-based competition to promote reporting; (3) development of an end-of-shift safety report; (4) executive leadership-sponsored rounds and incentives; and (5) a multidisciplinary workgroup to promote reporting. The program increased the reporting of potential errors dramatically, by 1,468 percent, in the 6-month pilot phase of the program and spurred the development of action plans designed to address the common causes of potential errors.

2. **Patient Safety Toolbox for States**
<http://www.innovations.ahrq.gov/content.aspx?id=308>

This electronic toolbox is featured on the Agency for Healthcare Research and Quality’s Health Care Innovations Exchange Web site. It is intended to provide States with tools they can use or modify as they develop or improve adverse event reporting systems. The tool box includes information (policies, practices, forms, reports, methods, and contracts) related to State reporting systems, links to other Web resources, and fast facts and issues related to patient safety.

3. **Reducing Errors in Health Care: Translating Research into Practice**
<http://innovations.ahrq.gov/content.aspx?id=784>

This fact sheet is featured on the Agency for Healthcare Research and Quality’s Health Care Innovations Exchange Web site. It provides research-based information on medical errors and how to reduce them. It addresses patients at risk, how errors occur, improving patient safety, and promoting safety.

Cross-references to resources already described:

- See Dimension 4. Organizational Learning—Continuous Learning, # 3 [Error Proofing](#)

Dimension 9. Teamwork Across Units

Cross-references to resources already described:

- See Dimension 1. Teamwork Within Units, #3 [Patient Safety Primer: Teamwork Training](#)
- See Dimension 1. Teamwork Within Units, Item #4, [Patient Safety Through Teamwork and Communication Toolkit](#)
- See Dimension 1. Teamwork Within Units, Item #5, [TeamSTEPPS™ - Team Strategies and Tools to Enhance Performance and Patient Safety](#)

Dimension 10. Staffing

1. **Hospital Nurse Staffing and Quality of Care**
<http://www.ahrq.gov/research/nursestaffing/nursestaff.htm>

This report summarizes the findings of AHRQ-funded and other research on the relationship of nurse staffing levels to adverse patient outcomes. This valuable information can be used by decisionmakers to make more informed choices in terms of adjusting nurse staffing levels and increasing nurse recruitment while optimizing quality of care and improving nurse satisfaction.

2. **Resident Duty Hours: Enhancing Sleep, Supervision, and Safety**
<http://www.iom.edu/~media/Files/Report%20Files/2008/Resident-Duty-Hours/residency%20hours%20revised%20for%20web.ashx>

This December 2008 report brief for an AHRQ-funded study from the Institute of Medicine (IOM) confirms that acute and chronically fatigued medical residents are more likely to make mistakes that affect patient care. The IOM recommends several changes to the existing 80-hour-per-week limit on resident work hours. For example, the IOM recommends that: residency programs provide opportunities for sleep each day and each week during resident training, the Accreditation Council for Graduate Medical Education provide better monitoring of duty hour limits, and residency review committees set guidelines for residents' patient caseloads.

Dimension 11. Handoffs & Transitions

1. **Door-to-Doc Patient Safety Toolkit**
<http://innovations.ahrq.gov/content.aspx?id=1952>

This toolkit is featured on the Agency for Healthcare Research and Quality's Health Care Innovations Exchange Web site. "Door to Doc" is a patient flow redesign process that improves the safety of care for patients in the emergency department (ED) by reducing the time patients wait to be seen and by expediting admission to the most appropriate hospital unit.

2. **Handoff of Care Frequently Asked Questions**
http://www.healthsystem.virginia.edu/internet/e-learning/handoff_faq.pdf

This resource from University of Virginia Health System identifies a strategy to improve handoff communication called IDEAL (Identify, Diagnosis, Events, Anticipate, Leave).

3. **Handoffs and Signouts**

<http://www.psnet.ahrq.gov/primer.aspx?primerID=9>

The process of transferring responsibility for care is referred to as the "handoff," with the term "signout" used to refer to the act of transmitting information about the patient. The Agency for Healthcare Research and Quality (AHRQ) Patient Safety Network explains this topic further and provides links for more information on what's new in handoffs and signouts in the context of care during hospitalization.

4. **Handoffs and Transitions in the Emergency Department Setting**

<http://www.marylandpatientsafety.org/html/collaboratives/ed/documents/HandoffsTransitionCallDigest.pdf>

In order to provide collaborative teams with an opportunity to learn from our faculty and other collaborative teams, the Maryland Patient Safety Center hosted a call in September 2006 to discuss strategies that lead to more effective handoffs among staff and units in the hospital. This summary is intended to share this discussion and lessons learned from that call.

5. **Medication Reconciliation Toolkit**

<http://innovations.ahrq.gov/content.aspx?id=2433>

This medication reconciliation toolkit is featured on the Agency for Healthcare Research and Quality's Health Care Innovations Exchange Web site. From the Department of Defense (DoD) Patient Safety Program, this toolkit can help health care providers ensure that their patients receive safe medical care. Medication reconciliation is a systematic process designed to improve communication during transitions of care that begins with the acquisition and generation of a current, accurate, and single source medication profile for use by all health care providers dealing with a specific patient at the time any form of care is delivered. This process promotes seamless communication among a patient's care providers to prevent inadvertent duplications or omissions.

6. **Medication Safety Reconciliation Toolkit**

<http://innovations.ahrq.gov/content.aspx?id=2173>

This medication safety reconciliation toolkit is featured on the Agency for Healthcare Research and Quality's Health Care Innovations Exchange Web site. It helps hospitals establish and implement a standardized medication reconciliation process. The toolkit provides guidance, sample forms, and tips.

7. **Medications At Transitions and Clinical Handoffs (MATCH) Initiative**

<http://innovations.ahrq.gov/content.aspx?id=1979>

This resource is featured on the Agency for Healthcare Research and Quality's Health Care Innovations Exchange Web site. The goal of the Medications At Transitions and Clinical Handoffs (MATCH) Initiative is to measurably decrease the number of discrepant medication orders and the associated potential and actual patient harm. This toolkit is designed to assist all types of organizations, whether caring for inpatients or outpatients or using an electronic medical record, a paper-based system, or both.

8. **Perioperative Patient 'Hand-Off' Tool Kit**

<http://www.aorn.org/PracticeResources/ToolKits/PatientHandOffToolKit/>

AORN and the U.S. Department of Defense Patient Safety Program collaboratively developed this new web-based tool kit that provides the resources to guide perioperative professionals in standardizing hand-off communications among caregivers. The tool kit, based on the Department of Defense Patient Safety Program TeamSTEPS™ initiative, will help develop consistency in communications needed for effective patient care. The AORN Patient Hand-Off Tool Kit includes supporting research for evidence-based

recommendations on perioperative patient hand offs, sample checklists and forms, PowerPoint presentations on standardizing communication and information exchanges in perioperative practice, and an annotated guide to additional resources.

9. **Project RED (Re-Engineered Discharge) Toolkit**

<http://innovations.ahrq.gov/content.aspx?id=2180>

This toolkit is featured on the Agency for Healthcare Research and Quality's Health Care Innovations Exchange Web site. These tools were developed to facilitate the Project RED (Re-Engineered Hospital Discharge) intervention. Project RED is a randomized controlled trial at Boston Medical Center. This project re-engineers the workflow process and improves patient safety for patients from a network of community health centers discharged from a general medical service at an urban hospital serving a low-income, ethnically diverse population. The toolkit includes:

- After Hospital Care Plan (AHCP) sample form
- Training manual
- A description of the computerized workstation and process used to create and print the AHCP

10. **Strategies and Tools to Improve Healthcare Handoffs and Transitions**

<http://www.unmc.edu/rural/patient-safety/tool-time/TT2-053006-DOD-SBAR-SafetyBriefings/DOD%20Handoff%20-%20I%20Pass%20the%20Baton.pdf>

This resource from the Department of Defense provides an overview on the importance of structured handoff processes and provides information on the Joint Commission requirement. The resource illustrates a handoff communication tool which can be recalled through the mnemonic device, "I PASS THE BATON".

11. **Strategies to Improve Handoffs**

<http://innovations.ahrq.gov/content.aspx?id=2188>

This tool is featured on the Agency for Healthcare Research and Quality's Health Care Innovations Exchange Web site. From the Maryland Patient Safety Center, it provides an outline of recommended strategies to improve the handoff process in hospitals (i.e., patient transitions in care from one provider to another).

11. **Transitions of Care Checklist**

http://www.ntocc.org/Portals/0/TOC_Checklist.pdf

The National Transitions of Care Coalition (NTOCC) Advisory Task Force has released a transitions of care list that provides a detailed description of effective patient transfer between practice settings. This process can help to ensure that patients and their critical medical information are transferred safely, timely, and efficiently.

Dimension 12. Nonpunitive Response to Error

1. **"Nonpunitive Response to Error" The Fair and Just Principles of the Aurora Health Care Culture**

https://www.cahps.ahrq.gov/content/community/events/files/T-6-S_Leonhardt-Final_fwp.pdf

This presentation from the AHRQ Surveys on Patient Safety Culture User Group Meeting describes Aurora Health Care's approach to creating of a culture of safety and reviews the action steps taken to address the "Nonpunitive Response to Error" dimension in the SOPS survey.

2. **Patient Safety and the "Just Culture": A Primer for Health Care Executives**

<http://psnet.ahrq.gov/resource.aspx?resourceID=1582>

Accountability is a concept that many leaders wrestle with as they steer their organizations and patients toward understanding and accepting the idea of a blameless culture within the context of medical injury. This report by David Marx is available for download through the Agency for Healthcare Research and Quality (AHRQ) Patient Safety Network and outlines the complex nature of deciding how best to hold individuals accountable for mistakes.

3. **Patient Safety and the "Just Culture": A Presentation by David Marx, JD**

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

This presentation on "Patient Safety and the Just Culture" by David Marx, JD defines just culture, the safety task, the just culture model, and statewide initiatives in New York.

Cross-references to resources already described:

- See Dimension 7. Communication Openness, #1, [Arizona Hospital and Healthcare Association SBAR Communication](#)
- See Dimension 4. Organizational Learning – Continuous Improvement, # 2, [Decision Tree for Unsafe Acts Culpability](#)
- See Dimension 8. Frequency of Events Reported, #1 [The Good Catch' Program Increases Reporting & Leads to Action Plans to Enhance Safety](#)
- See Dimension 7. Communication Openness, #2, [SBAR Technique for Communication: A Situational Briefing Model](#)
- See Dimension 4. Organizational Learning—Continuous Learning, #8 [Voluntary System to Report and Analyze Nursing Errors Leads to Patient Safety Improvements](#)