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

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* (HSOPS, available at 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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Contents

Alphabetical Index of Resources

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. Hospitals can put many findings from AHRQ research into practice in 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 by focusing on specific goals. This Web site contains a link to the latest goals, which include improvements emanating from the Standards Improvement Initiative. In addition, it has information regarding the new numbering system and minor language changes for consistency.

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 by focusing on specific goals. This Web site contains a link to the latest goals, which include improvements emanating from the Standards Improvement Initiative. In addition, it has information regarding the new numbering system and minor language changes for consistency.

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/

   AHRQ'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. A particular emphasis is placed 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

   AHRQ's 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/

   The 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 AHRQ document 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 multiyear AHRQ initiative to support the assessment of consumers' experiences with health care. This Web site provides information on the CAHPS Hospital Survey (H-CAHPS), 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. **Chasing Zero: Winning the War on Healthcare Harm**

http://discoveryhealthcme.discovery.com/zero/media/program.html

A near fatal medical error almost cost the lives of twins born to actor Dennis Quaid and his wife. This real-life event inspires a new patient education documentary featuring the Quaid family's personal ordeal, along with stories of other families who faced medical errors. It also features experts who are leading efforts to help health care providers reduce medical errors and improve patient safety outcomes.

12. **The Commonwealth Fund**

http://www.commonwealthfund.org/

The Commonwealth Fund is a private foundation that promotes a high-performing health care system that achieves better access, improved quality, and greater efficiency. A particular focus is vulnerable populations, including low-income people, uninsured people, minority Americans, children, and older adults. The Commonwealth Fund provides information on numerous health care topics, free publications, and innovations and tools for improving health care.

13. 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 want to prevent harm in health care encounters through partnership and collaboration. CAPS features a transitions toolkit (available at http://www.patientsafety.org/page/transtoolkit/) titled "Taking Charge of Your Healthcare: Your Path to Being an Empowered Patient."

14. Department of Defense Patient Safety Program

http://health.mil/dodpatientsafety

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). The program encourages a systems approach to create a safer patient environment; engages MHS leadership; promotes collaboration across all three Services; and fosters trust, transparency, teamwork, and communication.

15. Institute for Healthcare Improvement

http://www.ihi.org/ihi

IHI is a reliable source of energy, knowledge, and support for an ongoing 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.

16. 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.

17. The Joint Commission: Patient Safety

http://www.jointcommission.org/topics/patient_safety.aspx

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.

18. 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.

19. 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.

20. 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 health care system for the patients and families it serves. NPSF is committed to on uniting disciplines and organizations across the continuum of care, championing a collaborative, inclusive, multistakeholder approach.

21. 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 health care 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.

22. Partnering With Patients To Create Safe Care

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

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

23. Patient Safety in Small Rural Hospitals

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

In July 2005, AHRQ awarded the University of Nebraska Medical Center a 2-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.

24. 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 current patient safety articles and highlights patient safety initiatives and tools. Users can browse by care setting, event (e.g., falls, medication errors), discipline, audience, and patient safety focus.

25. 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 health care delivery environment for patients, workers, and their communities.

26. Transforming Hospitals: Designing for Safety and Quality

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

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

27. WHO Collaborating Centre for Patient Safety Solutions

http://www.ccforpatientsafety.org/patient-safety-solutions

The Joint Commission, Joint Commission International, and World Health Organization host a center for patient safety solutions. This Web site provides information about nine solutions for improving patient safety approved by the International Steering Committee. They address the following issues: (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 Misconnections, (8) Single Use of Injection Devices, and (9) Improved Hand Hygiene to Prevent Health Care-Associated Infection.

28. Why Not the Best?

http://whynotthebest.org/contents/

Why Not the Best is a health care quality improvement resource from The Commonwealth Fund. It shares lessons 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 Receives Positive Reviews, Enhances Communication and Teamwork Among Labor and Delivery Practitioners During Crises

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

This featured profile is available on AHRQ's Health Care Innovations Exchange Web site. Crisis Resource Management (CRM) is a 7-hour course for labor and delivery (L&D) practitioners. It uses 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 postimplementation 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 AHRQ'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 obstetric 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 AHRQ Patient Safety Network explains this topic further and provides links for more information on what is 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 AHRQ'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. **Pennsylvania Patient Safety Advisory (Vol.7, Suppl. 2)**

   http://psnet.ahrq.gov/resource.aspx?resourceID=18509&sourceID=1&emailID=6

   This supplement from the Pennsylvania Patient Safety Authority is available for download from the AHRQ Patient Safety Network. It outlines tactics to improve communication, including crew resource management, chain-of-command policies, and teamwork training.

6. **TeamSTEPPS™ — Team Strategies and Tools to Enhance Performance and Patient Safety**

   http://teamstepps.ahrq.gov/

   Developed jointly by the Department of Defense (DoD) and AHRQ, TeamSTEPPS™ is a resource for training health care 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 health care quality. Following extensive field testing in the MHS and several civilian organizations, a multimedia TeamSTEPPS toolkit is now available in the public domain to civilian health care 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 an institution understand its level of readiness to initiate the TeamSTEPPS program. Users may find it helpful to have a colleague review their 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. The module contains the Instructor Guide in electronic form and 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 and Dimension 3. Management Support for Patient Safety

1. **Appoint a Safety Champion for Every Unit**

   http://www.ihi.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 IHI Web site identifies tips for appointing a safety champion.

2. **Conduct Patient Safety Leadership WalkRounds™**

   http://www.ihi.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 IHI Web site discusses the benefits of 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. **A Framework for Leadership Improvement**

   http://www.ihi.org/IHI/Topics/LeadingSystemImprovement/Leadership/EmergingContent/AFrameworkforLeadershipofImprovement.htm

   This framework, developed by IHI, was built on 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.ihi.org/IHI/Programs/Campaign/BoardsonBoard.htm

   This resource from IHI 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 guide is part of IHI'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 needed to ensure that patients are not harmed by the 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 staff introduce innovations to their organization? How do they encourage others to think "outside the box" and accept new ideas? Users can browse the Learn & Network part of this site to find advice and ideas from experts and practitioners, insights from the literature, and opportunities to participate in discussions and learning networks on specific topics.

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

http://www.ihi.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 IHI's Web site. Users can consult this decision tree when analyzing an error or adverse event that has occurred in their organization. It can help identify how human factors and system issues contributed to the event. This decision tree is particularly helpful when working toward a nonpunitive approach in an organization.

3. **Error Proofing**

http://www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/Changes/Error+Proofing.htm

Errors occur when actions do not agree with intentions even though people are capable of carrying out the task. This Web site from 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.ihi.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 results (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 AHRQ's Health Care Innovations Exchange. It includes practical examples on the use of process and design features to prevent medical errors or the negative impact of errors. It contains more than 150 examples of mistake proofing that can be applied to health care, in many cases relatively inexpensively. Risk managers and chief medical officers can benefit from commonsense approaches to reducing risk and litigation. 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 AHRQ Patient Safety Network explains this topic further and provides links for more information on what is new in RCA.

7. **VA National Center for Patient Safety: NCPS Root Cause Analysis Tools**

   http://www.va.gov/ncps/CogAids/RCA/index.html

   Since 1999, NCPS has developed tools, training, and software to facilitate patient safety and RCA investigations. This guide functions as a cognitive aid to help teams in developing a chronological event flow diagram (an understanding of what occurred) and a cause and effect diagram (why the event occurred). RCA teams have found this book an effective aid with these challenging 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 AHRQ'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. They are 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. These recommendations covered organizational, individual, and technical improvements that could be made to reduce the chance of recurrence. Although the number of participating nurses was limited, the changes the hospital systems made helped to address a wide variety of safety problems that were directly under the control of these organizations and led to the adoption of many 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 AHRQ'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.
   - A sample grid for listing committee assignments to document and demonstrate the interdisciplinary aspects of the organization's safety program.
   - A document shared by the American Society of Healthcare Risk Management that may be helpful for developing a process for disclosing medical errors to patients and family.
   - Checklist for patient safety and Joint Commission on the Accreditation of Healthcare Organizations standards.

2. **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 at 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.

3. **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 AHRQ'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.

4. **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 AHRQ Patient Safety Network explains this topic further and provides links for more information on what is new in safety culture.

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

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

   This toolkit is featured on AHRQ'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.

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

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

   This toolkit is featured on AHRQ'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 IHI.

Dimension 6. Feedback and Communication About Error

1. **Conduct Safety Briefings**

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

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

2. **Provide Feedback to Frontline Staff**

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

   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 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 assist facilities through the implementation and training of SBAR communication. This toolkit includes samples of SBAR documents; staff education, including practice scenarios to use SBAR; and policy recommendations.

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

   http://www.ihi.org/IHI/Topics/PatientSafety/SafetyGeneral/Tools/SBARTechniqueforCommunicationASituationalBriefingModel.htm

   The SBAR technique provides a framework for communication between members of the health care team about a patient's condition. This downloadable tool from IHI includes two documents. The document "SBAR Report to Physician About a Critical Situation" is a worksheet/script that a provider can use to organize information when preparing to

communicate 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:

- Dimension 1. Teamwork Within Units, # 1 Crisis Management Simulation Course.
- Dimension 1. Teamwork Within Units, # 2 Curricula for Simulated Obstetric Emergency Response Drills & Safety (CORDS).
- Dimension 1. Teamwork Within Units, # 4 Patient Safety Through Teamwork and Communication Toolkit.
- Dimension 1. Teamwork Within Units, #5 Pennsylvania Patient Safety Advisory.

Dimension 8. Frequency of Events Reported

1. **Multifaceted Program Increases Reporting of Potential Errors, Leads to Action Plans to Enhance Safety**

   http://www.innovations.ahrq.gov/content.aspx?id=273

   This featured profile is available on AHRQ'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. The program was designed to increase the reporting of potential errors related to medication, equipment, and patient care. Key elements of the program include (1) a change in use of terminology from negative to positive terms and phrases (e.g., from "close call" or "near miss" to "good catch"); (2) friendly, team-based competition to promote reporting; (3) development of an end-of-shift safety report; (4) executive leadership-sponsored rounds and incentives; and (5) a multidisciplinary workgroup to promote reporting. The program increased the reporting of potential errors dramatically, by 1,468 percent, in the 6-month pilot phase of the program and spurred the development of action plans designed to address the common causes of potential errors.

2. **Patient Safety Toolbox for States**

   http://www.innovations.ahrq.gov/content.aspx?id=308

   This electronic toolbox is featured on AHRQ'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 toolbox 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 AHRQ'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, ways to improve patient safety, and ways to promote safety.

Cross-reference to resource already described:

- Dimension 4. Organizational Learning—Continuous Learning, # 3 Error Proofing.

Dimension 9. Teamwork Across Units

Cross-references to resources already described:

- Dimension 1. Teamwork Within Units, #3 Patient Safety Primer: Teamwork Training.
- Dimension 1. Teamwork Within Units, #4 Patient Safety Through Teamwork and Communication Toolkit.
- Dimension 1. Teamwork Within Units, #5 Pennsylvania Patient Safety Advisory.
- Dimension 1. Teamwork Within Units, #6 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 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 limit on resident work hours of 80 hours per week. 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 and Transitions

1. Door-to-Doc Patient Safety Toolkit

http://innovations.ahrq.gov/content.aspx?id=1952

This toolkit is featured on AHRQ'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 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 the University of Virginia Health System identifies a strategy to improve handoff communication called IDEAL (Identify patient, Diagnosis, recent Events, Anticipated changes, Leave time for questions).

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 AHRQ Patient Safety Network explains this topic further and provides links for more information on what is 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/HandoffsTransition CallDigest.pdf

In order to provide collaborative teams with an opportunity to learn from their 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 Safety Reconciliation Toolkit

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

This medication safety reconciliation toolkit is featured on AHRQ'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.

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

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

   This resource is featured on AHRQ'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.

7. **Perioperative Patient "Hand-Off" Toolkit**

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

   The Association of periOperative Registered Nurses and the DoD Patient Safety Program collaboratively developed this new Web-based toolkit that provides resources to guide perioperative professionals in standardizing handoff communications among caregivers. The toolkit, based on the TeamSTEPPS initative, will help develop consistency in communications needed for effective patient care. The toolkit includes supporting research for evidence-based recommendations on perioperative patient handoffs, sample checklists and forms, PowerPoint presentations on standardizing communication and information exchanges in perioperative practice, and an annotated guide to additional resources.

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

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

   This toolkit is featured on AHRQ'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 reengineers 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.

9. **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 DoD resource 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 that can be recalled through the mnemonic device, "I PASS the BATON."

10. **Strategies To Improve Handoffs**

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

   This tool is featured on AHRQ'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 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 in a safe, timely, and efficient manner.

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 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, J.D.**

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

   This presentation defines just culture, the safety task, the just culture model, and statewide initiatives in New York.

Cross-references to resources already described:

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