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

Purpose

This document contains references to Web sites that provide practical resources nursing homes 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 nursing homes 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) *Nursing Home 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. **2010 Long Term Care National Patient Safety Goals**
   http://www.jointcommission.org/patientsafety/nationalpatientsafetygoals/

   The purpose of The Joint Commission Long Term Care National Patient Safety Goals is to improve patient safety in a long-term care setting 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, the site has information on the new numbering system and minor language changes for consistency.

2. **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.

   Advancing Excellence in America's Nursing Homes
   http://www.nhqualitycampaign.org/star_index.aspx?controls=welcome

   Advancing Excellence in America's Nursing Homes is an ongoing coalition-based campaign concerned with how we care for older adults, chronically ill and disabled people, and people recuperating in a nursing home environment. This voluntary campaign monitors key indicators of nursing home care quality, both clinical quality and organizational improvement goals; promotes excellence in caregiving; acknowledges the critical role nursing home staff have in providing care; and recognizes the important role of consumers in contributing ideas and suggestions to the campaign.

3. **AHRQ Health Care Innovations Exchange**
   http://www.innovations.ahrq.gov/

   The 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 AHRQ'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

4. **AHRQ Medical Errors and Patient Safety**
   http://www.ahrq.gov/qual/errorsix.htm

   The Agency for Healthcare Research and Quality 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

5. **AHRQ Patient Safety Network**
   http://www.psnet.ahrq.gov/

   The 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.

6. **CAHPS® Nursing Home Surveys**
   http://www.cahps.ahrq.gov/content/products/NH/PROD_NH_Intro.asp

   The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) program is a multiyear AHRQ initiative. This Web site provides information on the CAHPS Nursing Home Surveys, as well as links to three separate instruments: an in-person questionnaire for long-term residents, a mail questionnaire for recently discharged short-stay residents, and a questionnaire for residents' family members.

7. **Centers for Medicare & Medicaid Services (CMS): Nursing Homes**
   http://www.cms.hhs.gov/CertificationandComplianc/12_NHs.asp
   This page provides basic information about being certified as a Medicare or Medicaid nursing home provider and includes links to applicable laws, regulations, and compliance information. The site also has related nursing home reports, compendia, and a list of special focus facilities (i.e., nursing homes with a record of poor survey [inspection] performance on which CMS focuses extra attention) available for download.

8. **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.

9. **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. Efforts are aimed particularly at society's most vulnerable populations, including low-income people, uninsured people, racial and ethnic minority groups, young children, and older adults. The Commonwealth Fund provides information on a variety of health care topics, free publications, and innovations and tools for improving health care.

10. **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/142046/) titled "Taking Charge of Your Healthcare: Your Path to Being an Empowered Patient."

11. **Department of Defense Patient Safety Program**
    http://health.mil/dodpatientsafety

    The Department of Defense Patient Safety Program is a comprehensive program designed to establish 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.

12. **Enhanced Toileting Program Reduces Incontinence and Its Comorbidities Among Residents of Long-Term Care Facility**
    http://www.innovations.ahrq.gov/content.aspx?id=2245

    This featured profile is available on the AHRQ Health Care Innovations Exchange Web site. A long-term care facility adopted an enhanced toileting program consisting of the following components: individualized toileting plan of care based on periodic resident assessments, revised and new care documentation tools, devices to assist with toileting, and comprehensive education and training for facility staff. The program led to a sharp decline in the prevalence of incontinence (from 76 to 38 percent of residents) and in associated comorbidities and staff injuries.

13. **Facility Assessment: Checklists for Activities of Daily Living**
http://www.innovations.ahrq.gov/content.aspx?id=1657

This 11-page quality tool is featured on the AHRQ Health Care Innovations Exchange Web site. It provides self-assessment checklists for nursing home staff to use in assessing processes related to declines in activities of daily living (ADL) among facility residents, in order to identify areas that need improvement. These checklists focus primarily on issues related to the "late-loss" ADLs of transfers, toilet-use, bed mobility, and eating. This tool includes checklists on the following ADL-related topics: screening for ADL function and decline, assessment, care plans, monitoring and reassessment of ADL function, and staff education and training.

14. **Facility Assessment: Checklists for Delirium**
http://www.innovations.ahrq.gov/content.aspx?id=1665

This 11-page quality tool is featured on the AHRQ Health Care Innovations Exchange Web site. It provides self-assessment checklists for nursing home staff to use in assessing processes related to delirium in the facility, in order to identify areas that need improvement. This tool includes checklists on the following delirium-related topics: delirium assessment, delirium care plans, delirium screening, and staff education and training.

15. **Home-Like, Self-Directed Environment Provides Superior Quality of Life Than in Traditional Nursing Homes and Assisted Living Facilities**
http://www.innovations.ahrq.gov/content.aspx?id=1857

This featured profile is available on the AHRQ Health Care Innovations Exchange Web site. THE GREEN HOUSE® model provides older adults with an alternative to nursing homes and traditional assisted living facilities. These communities provide groups of 7 to 10 older adults a comfortable, warm, home environment and staff who provide the highest level of clinical care while nurturing relationships and older adults' autonomy. A 30-month evaluation suggests that THE GREEN HOUSE® adults receive equal or higher quality of care and report better quality of life than residents of nursing homes.

16. **Immunizations Toolkit**
http://www.innovations.ahrq.gov/content.aspx?id=1684

This toolkit is featured on the AHRQ Health Care Innovations Exchange Web site. It was developed to increase immunization rates among nursing home residents and staff. It offers specific information and education on the benefits of influenza (flu) and pneumonia immunization, as well as sample guidelines and tools needed to run an effective and sustainable resident and staff immunization program.

17. Institute for Healthcare Improvement
http://www.ihi.org/ihi

The Institute for Healthcare Improvement 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.

18. 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
- Food and Drug Administration 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

19. 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.

20. 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 Department of Veterans Affairs. The primary intended audience for the public Web site is health care professionals and health care administrators.

21. National Patient Safety Foundation®
http://www.npsf.org/

The National Patient Safety Foundation® has been 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 unwavering in its determined and committed focus on uniting disciplines and organizations across the continuum of care, championing a collaborative, inclusive, multistakeholder approach.

22. 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.

23. Nursing Home "Neighborhoods" Emphasize Dignity and Independence, Leading to Improvements in Resident Health and Quality of Life and Lower Employee Turnover
http://www.innovations.ahrq.gov/content.aspx?id=1906

This featured profile is available on the AHRQ Health Care Innovations Exchange Web site. Providence Mount St. Vincent (known as "The Mount") developed and implemented a new model for nursing home care in which most residents live in a "neighborhood" of 20 to 23 residents containing a cluster of private and semiprivate rooms and a large kitchen/dining area that serves as the central gathering spot for meals and activities. The Mount's approach also focuses on giving residents more independence, autonomy, and dignity than in a traditional nursing home, leading to a greater sense of community and a higher quality of life for residents, as well as a better work environment for employees.

24. Nutrition Care Alerts: Warning Signs and Action Steps for Caregivers in Nursing Facilities
http://www.innovations.ahrq.gov/content.aspx?id=288

This featured profile is available on the AHRQ Health Care Innovations Exchange Web site. This guide, developed by nutrition and long-term care experts, can help caregivers of nursing home residents learn more about the warning signs of poor nutrition and practical steps to maintain and improve residents' nutritional health. Warning signs include unintended weight loss, dehydration, pressure ulcers, and complications from tube feeding.

25. Pennsylvania Patient Safety Authority
http://www.patientsafetyauthority.org/Pages/Default.aspx

The Pennsylvania Patient Safety 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.

26. 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. 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.

Falls Management/Prevention

1. **Falls in Nursing Homes Fact Sheet**
   http://www.premierinc.com/safety/topics/falls/downloads/E-02-falls-nursing-homes.doc

   This fact sheet identifies the problem of falls in nursing homes and offers strategies for preventing falls.

2. **Falls Management Program**
   http://www.qualitynet.org/dcs/ContentServer?cid=1136495771104&pagename=Medqic/MQTools/ToolTemplate&c=MQTools

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

3. **Interdisciplinary Team Identifies and Addresses Risk Factors for Falls Among Nursing Home Residents, Leading to Fewer Falls and Less Use of Restraints**
   http://www.innovations.ahrq.gov/content.aspx?id=1835

   This featured profile is available on the AHRQ Innovations Exchange Web site. Ethica Health and Retirement Communities has developed a falls management program, the cornerstone of which is an interdisciplinary "falls team" at each nursing home that regularly assesses residents for their risk of falling and develops intervention plans for those found to be at high risk. The team also documents and investigates every fall and takes steps to reduce the chance of recurrence. The program led to a slight decline in falls and a large reduction in use of restraints.

4. **Limiting Physical Restraint Use**
   http://www.primaris.org/Physical%20Restraints

   Primaris and a group of Missouri nursing homes collaborated on a 3-year project to reduce the use of physical restraints. This Web site provides background information on restraints and free quality improvement resources on this topic, including a variety of checklists and educational materials.

5. **Department of Veteran Affairs National Center for Patient Safety 2004 Falls Toolkit**
   http://www.va.gov/ncps/SafetyTopics/fallstoolkit/index.html

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

6. **Best Practice Intervention Tools for Fall Prevention**
   http://www.innovations.ahrq.gov/content.aspx?id=2094

   The Best Practice Intervention Packages (BPIP) are featured on the AHRQ Health Care Innovations Exchange Web site. The packages were designed for use by any home health agency to support efforts to reduce avoidable acute care hospitalizations. The topic of this package is falls prevention.

Reducing Pressure Ulcers

1. **Braden Scale for Predicting Pressure Sore Risk**
   http://www.innovations.ahrq.gov/content.aspx?id=2403

   This rating scale for nurses and other health care providers is featured on the AHRQ Health Care Innovations Exchange Web site. It predicts a patient's level of risk for developing pressure ulcers. The scale is composed of six subscales that measure functional capabilities of the patient that contribute to either higher intensity and duration of pressure or lower tissue tolerance for pressure.

2. **Nursing Home Improvement Feedback Tool**
   http://www.innovations.ahrq.gov/content.aspx?id=2193

   This tool is featured on the AHRQ Health Care Innovations Exchange Web site. The Nursing Home Improvement Feedback Tool (NHIFT, or "nifty") is a computer-based audit and feedback tool that assists nursing homes in collecting data and viewing process measure scores for four clinical topics: depression, pain, physical restraints, and pressure ulcers.

3. **On-Time Quality Improvement for Long-Term Care**
   http://www.ahrq.gov/research/ontime.htm

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

4. **Prevention and Treatment Program Integrates Actionable Reports Into Practice, Significantly Reducing Pressure Ulcers in Nursing Home Residents**
   http://www.innovations.ahrq.gov/content.aspx?id=2153

   This featured profile is available on the AHRQ Health Care Innovations Exchange Web site. The On-Time Pressure Ulcer Prevention and Treatment Program uses standardized documentation data elements and actionable clinical reports that are integrated into practice at nursing homes; the goal of the program is to help nursing home staff identify and address risk factors for pressure ulcers in residents.

5. **Staff Training and Support, Incentives, and Feedback Fails to Generate Sustainable Reductions in Pressure Ulcers at Nursing Home**
   http://www.innovations.ahrq.gov/content.aspx?id=1895

   This profile is available on the AHRQ Health Care Innovations Exchange Web site. Guided by a university research team, a 136-bed, not-for-profit nursing home in Pennsylvania implemented a quality improvement program to reduce the incidence of pressure ulcers (PUs). The program had three components: increasing workers' ability to recognize and prevent PUs, giving them incentives to perform better, and providing management and staff with performance feedback. Although there was a significant reduction in PUs during the program's 3-month implementation period, these gains were not sustained.

Resources by Dimension

The following resources are organized according to the relevant Nursing Home Survey on Patient Safety Culture dimensions they can help improve. Some resources are duplicated and cross-referenced because they may apply to more than one dimension.

Dimension 1. Overall Perceptions of Resident 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 AHRQ 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. **Improving Resident Safety in Long-term Care Facilities**
   http://www.medi-smart.com/improving-resident-safety-in-long-term-care-facilities2.htm

   This article identifies tips for improving resident safety, including general information and specific tips on falls and wanderers.

3. **Making Health Care Safer: A Critical Analysis of Patient Safety Practices, Evidence Report/Technology Assessment**
   http://innovations.ahrq.gov/content.aspx?id=399

   This evidence report is featured on the AHRQ 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. These are 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 the AHRQ 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.

Dimension 2. Feedback and Communication About Incidents

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 Institute for Healthcare Improvement Web site 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 frontline staff is a critical component of demonstrating a commitment to safety and ensuring that staff members continue to report safety issues. This Institute for Healthcare Improvement Web site identifies tips and tools for providing feedback.

Dimension 3. Supervisor Expectations and Actions Promoting Resident Safety and Dimension 4. Management Support for Resident 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 Institute for Healthcare Improvement 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 organization by making regular rounds to discuss safety issues with frontline staff. This Institute for Healthcare Improvement 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. **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.

Dimension 5. Organizational Learning

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, 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 the Institute for Healthcare Improvement Web site. This decision tree can be used to analyze an error or adverse event that has occurred in an organization to help identify how human factors and systems issues contributed to the event. This decision tree is particularly helpful when working toward a nonpunitive approach.

3. **Error Proofing**
   http://www.ihi.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 outlines error proofing. It includes links to the following topics for more specific information and strategies: Use Affordances, Use Constraints, Use Differentiation, and 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), carry out the test (Do), observe and learn from the consequences (Study), and determine 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 AHRQ Health Care Innovations Exchange Web site. Mistake-Proofing the Design of Health Care Processes is a synthesis of practical examples from the world of health care on the use of process or 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 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. **Nursing Home Learning Collaborative Improves Quality of Care, Reduces Staff Turnover**
   http://www.innovations.ahrq.gov/content.aspx?id=259

   This featured profile is available on the AHRQ Innovations Exchange Web site. In this approach to improving nursing home care, known as the "Wellspring Model," nursing homes

come together in a learning collaborative to exchange performance data and conduct group training for both staff and leadership on quality improvement processes.

7. **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.

8. **A Systems Approach to Quality Improvement in Long-Term Care: Safe Medication Practices Workbook**
   http://psnet.ahrq.gov/resource.aspx?resourceID=5148

   This manual available for download through the AHRQ Patient Safety Network provides nursing home staff with a step-by-step guide for medication management to reduce medication errors in long-term care.

9. **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 develop 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 difficult activities.

10. **Will It Work Here?: A Decisionmaker's Guide to Adopting Innovations**
    http://www.innovations.ahrq.gov/resources/guideTOC.aspx

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

Dimension 6. Training and Skills

1. **Try This: Best Practices in Nursing Care to Older Adults**
   http://www.innovations.ahrq.gov/content.aspx?id=2105

   "Try This" is a series of assessment tools where each issue focuses on a topic specific to the older adult population. The content is directed to orient and encourage all nurses to understand the special needs of older adults and to use the highest standards of practice in caring for older adults.

Dimension 7. Compliance With Procedures

There are no resources identified at this time.

Dimension 8. Teamwork

1. **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.

2. **Patient Safety Through Teamwork and Communication Toolkit**
   http://innovations.ahrq.gov/content.aspx?id=1947

   This toolkit is featured on the AHRQ 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 of each of the following tools along with provisions for implementation: Multidisciplinary Rounding, Huddles, Rapid Response and Escalation, and Structured Communication.

3. **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 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 Military Health System (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 include.

   - "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 provides 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 9. Handoffs

1. **Cooperative Network Improves Patient Transitions Between Hospitals and Skilled Nursing Facilities, Reducing Readmissions and Length of Hospital Stays**
   http://www.innovations.ahrq.gov/content.aspx?id=2162

   This featured profile is available on the AHRQ Health Care Innovations Exchange Web site. Summa Health System's Care Coordination Network strives to ensure smooth transitions between the hospitals and 37 local skilled nursing facilities, leading to fewer readmissions and lower length of stay in the hospital.

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, Diagnosis, Events, Anticipate, Leave).

3. **Fax Back Sheet**
   http://www.innovations.ahrq.gov/content.aspx?id=2508

   This profile is available on the AHRQ Health Care Innovations Exchange Web site. Physicians need to know specific information before writing or changing an order related to pain management. This fax back sheet assists nursing home staff (primarily nursing and pharmacy staff) in assembling the needed information before calling the physician. This sheet makes the information exchange and the decisionmaking process more efficient and effective.

4. **Medications At Transitions and Clinical Handoffs (MATCH) Initiative**
   http://innovations.ahrq.gov/content.aspx?id=1979

   This toolkit is featured on the AHRQ Health Care Innovations Exchange Web site. The goal of the 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.

5. **Post-Acute Transfer Form**
   http://www.innovations.ahrq.gov/content.aspx?id=186

   This profile is available on the AHRQ Health Care Innovations Exchange Web site. This form is used to standardize information transferred between acute care hospitals and skilled nursing facilities throughout the four-county northeastern Ohio region. It may be adapted for use in other areas. It includes information on medications, activities of daily living, orders, and special care needs.

6. **Planning for Your Discharge: A Checklist for Patients and Caregivers Preparing to Leave a Hospital, Nursing Home, or Other Health Care Setting**
   http://www.innovations.ahrq.gov/content.aspx?id=2578

   This profile is available on the AHRQ Health Care Innovations Exchange Web site. This patient handout can help patients, caregivers, and medical staff communicate as patients prepare to leave a hospital, nursing home, or other health care setting. The booklet provides many questions and prompts for patients and caregivers so that they can gather information to ensure a safe discharge.

Dimension 10. 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 a facility through the implementation and training of SBAR communication. Items included in this toolkit are 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 (Situation-Background-Assessment-Recommendation) technique provides a framework for communication between members of the health care team about a patient's condition. This downloadable tool from the Institute for Healthcare Improvement contains two documents. "SBAR Report to Physician About a Critical Situation" is a worksheet/script that a provider can use to organize information in preparing to communicate with a physician about a critically ill patient. "Guidelines for Communicating With Physicians Using the SBAR Process" explains how to carry out the SBAR technique.

Cross-reference to resource already described:

- Refer to Dimension 8. Teamwork, # 2, Patient Safety Through Teamwork and Communication Toolkit.

Dimension 11. Nonpunitive Response to Mistakes

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 a culture of safety and reviews the action steps taken to address the "Nonpunitive Response to Error" dimension in the 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 on "Patient Safety and the Just Culture" by David Marx defines just culture, the safety task, the just culture model, and statewide initiatives in New York.

Cross-references to resources already described:

- Refer to Dimension 10. Communication Openness, #1, Arizona Hospital and Healthcare Association SBAR Communication.
- Refer to Dimension 5. Organizational Learning, # 2, Decision Tree for Unsafe Acts Culpability.
- Refer to Dimension 10. Communication Openness, #2, SBAR Technique for Communication: A Situational Briefing Model.

Dimension 12. Staffing

1. **Workforce Retention in Long-Term Care: "What a Difference Management Makes"**
   http://www.riqualitypartners.org/2/Site/CustomFiles/Qlty_DocMgr/Eaton%20Summary.doc

   This article, available for download, discusses workforce retention in long-term care facilities and proposes suggestions for reducing staff.

2. **Workforce Strategies: Introducing Peer Mentoring in Long-Term Care Settings**
   http://www.directcareclearinghouse.org/download/WorkforceStrategies2.pdf

   This article identifies the benefits of peer mentoring in long-term care settings for staff retention and provides instructions on how to design a peer mentoring program.

3. **Creation of Households Program in Nursing Home Improves Residents' Health Status, Reduces Staff Turnover, and Boosts Demand for Services**
   http://innovations.ahrq.gov/content.aspx?id=2051

   This featured profile is available on the Agency for Healthcare Research and Quality's Innovations Exchange Web site. Meadowlark Hills, a retirement community, renovated one of its facilities so that residents can live together in group households and become more independent. The innovator noted that the change in approach led to improvements in residents' health, a sharp decrease in staff turnover, and a significant increase in demand for facility services, all without raising operating costs.

Cross-reference to resource already described:

- Refer to Dimension 5. Organizational Learning, #6, Nursing Home Learning Collaborative Improves Quality of Care, Reduces Staff Turnover.