Improving Patient Safety in Ambulatory Surgery Centers: A Resource List for Users of the AHRQ Ambulatory Surgery Center Survey on Patient Safety Culture

Purpose

This document contains references to Web sites that provide practical resources ambulatory surgery centers (ASCs) 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 ASCs looking for information about patient safety initiatives. This document will be updated periodically.

How To Use This Resource List

Resources are listed in alphabetical order, organized by the composites assessed in the Agency for Healthcare Research and Quality (AHRQ) *Ambulatory Surgery Center Survey on Patient Safety Culture* (available at: http://www.ahrq.gov/professionals/quality-patient-safety/patientsafetyculture/asc/index.html), followed by general resources.

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@westat.com.

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Resources by Composite

The following resources are organized according to the relevant Ambulatory Surgery Center Survey on Patient Safety Culture composites they can help improve. Some resources are duplicated and cross-referenced because they may apply to more than one composite.

Composite 1. Communication About Patient Information

1. Ambulatory Surgery Surgical Checklist
http://www.scoap.org/downloads/SCOAP-Surgical-Checklist-DRAFT-3-1.pdf

SCOAP (Surgical Care and Outcomes Assessment Program), a program of the Foundation for Health Care Quality, provides a free, downloadable surgical checklist for ambulatory surgery. The one-page checklist was adapted from the World Health Organization "Safe Surgery Saves Lives" campaign and a surgical checklist developed by the Washington State Ambulatory Surgery Association and Proliance Surgeons. It addresses what actions need to be taken during three steps: prior to incision, process control, and debriefing (at completion of case).

2. AORN Comprehensive Surgical Checklist
https://www.aorn.org/aorn-org/guidelines/clinical-resources/tool-kits/correct-site-surgery-tool-kit/aorn-comprehensive-surgical-checklist

The Association of periOperative Registered Nurses (AORN) Comprehensive Surgical Checklist was created to support a facility's need to use a single checklist that includes the safety checks outlined in the World Health Organization's (WHO) Surgical Safety Checklist, while also meeting the safety checks within The Joint Commission's Universal Protocol in order to meet accreditation requirements. It offers guidance for preprocedure check-in, sign-in, timeout, and sign out. Open-ended questions are also included under the timeout portion to encourage active participation from all members of the surgery team. This comprehensive surgical checklist was created in collaboration with AORN Perioperative Nursing Specialist Robin Chard, AORN President Charlotte Guglielmi, contributors to the WHO Surgical Safety Checklist, and representatives from The Joint Commission.

3. Gastroenterology Safe Surgery Checklist
http://www.gastro.org/practice/quality-initiatives/GI_Safe_Surg_Checklist.pdf

The American Gastroenterological Association, in partnership with the American College of Gastroenterology and the American Society for Gastrointestinal Endoscopy, has developed a safe surgery checklist for ambulatory surgery centers that provide gastroenterology services. The safe surgery checklist helps ensure certain measures or steps are taken prior to administration of anesthesia/sedation, prior to introduction of the endoscope, and prior to the patient leaving the procedure room. The checklist also provides space for quality improvement ideas.

4. Instructional Videos on Surgical Safety Checklist Use
http://www.safesurg.org/videos.html

Safesurg.org, a Web site designed to support individuals and institutions interested in improving the safety of surgical practices, provides free videos on the use of the World Health Organization's surgical safety checklist. The videos are intended to teach potential users how to and how *not* to perform the checklist in a real-world environment.

5. Ophthalmic Surgical Checklist - Ambulatory Surgery Center Association
http://www.ascassociation.org/HigherLogic/System/DownloadDocumentFile.ashx?DocumentFileKey=e456523c-a3f7-4ca8-b532-d5be7885c41b&forceDialog=0

The American Academy of Ophthalmology and Ophthalmic Mutual Insurance Company asked key ophthalmic societies to join them in developing a task force to devise an ophthalmic-specific surgical checklist. The task force produced a sample ophthalmic surgical checklist to meet the needs of patients having many kinds of procedures. Users of the checklist are encouraged to make any changes necessary to best address the type of patients, procedures, anesthesia, and facility they have. The developers recommend checking with the physicians, anesthesia providers, nurses, and facility administrators to determine which elements are required under state licensing rules or by accreditation organizations.

6. Patient Flow Worksheet for Surgery Centers
http://www.beckersasc.com/asc-accreditation-and-patient-safety/patient-safety-tool-patient-flow-worksheet-for-surgery-centers.html

Sandy Berreth, administrator of a surgery center in Minnesota, and an Accreditation Association for Ambulatory Health Care surveyor, provided *Becker's Operating Room Clinical Quality & Infection Control* with a patient flow worksheet template for use in ambulatory surgery centers.

7. Patient Safety Toolkit: Ambulatory Surgery and Surgical/Procedural Checklists
http://www.aaahc.org/Global/pdfs/AAAHC%20Institute%20content/Patient%20Safety%20Toolkits/PST_surgical%20checklists_FINAL.pdf

The Association of periOperative Registered Nurses, a member association of the Accreditation Association for Ambulatory Health Care (AAAHC), has developed the Comprehensive Surgical Checklist that combines items from the World Health Organization Surgical Safety Checklist and The Joint Commission Universal Protocol safety checks. This AAAHC tool offers guidance for preprocedure check-in, sign-in, timeout, and sign out. Open-ended questions are also included to encourage active participation from all members of the surgery team.

8. Safe Surgery 2015
http://www.safesurgery2015.org/

Ariadne Labs, a Joint Center of Innovation at Brigham and Women's Hospital, and the T.H. Chan Harvard School of Public Health launched an effort to improve the use of the World Health Organization's Surgical Safety Checklist. The Safe Surgery program aims to improve teamwork and communication in the operating room by leveraging the World Health

Organization Checklist as a teamwork and communication tool. This program also monitors the impact that the checklist has on culture and patient outcomes. Beginning with hospitals, the program has expanded for use in additional health facilities across the United States, including ambulatory surgery centers.

9. Same Day Surgery Handoff Card
https://www.outpatientsurgery.net/resources/forms/2015/pdf/OutpatientSurgeryMagazine_1115_Handoff.pdf

This patient handoff card was created for the ambulatory surgery environment by a practicing nurse and made available by *Outpatient Surgery* magazine. This tool can be used to communicate important patient information throughout the facility such as medical history, allergies, medications, and family contacts.

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

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.

- "Guidelines for Communicating With Physicians Using the SBAR Process" explains how to carry out the SBAR technique.
- "SBAR Report to Physician About a Critical Situation" is a worksheet/script that a provider can use to organize information in preparing to communicate with a physician about a critically ill patient.

Composite 2. Communication Openness

1. Stop-the-Line Assertive Statements Training
http://www.saferpatients.com/Newsletter/Stop%20the%20Line%20Assertive%20Statements%20Training.pdf

LifeWings offers a free tool to train health care staff on speaking up about patient safety risks. The tool explains the components of a "Stop-the-Line Assertive Statement": Get attention; Express concern; State the problem; Propose a solution. The training tool provides an opportunity for staff to draft assertive statements for 31 possible situations in which staff should speak up about a patient safety risk. The tool also includes 31 potential assertive statements staff members can use when speaking up.

Cross-references to resources already described:

- Composite 1. Communication About Patient Information, #1 Ambulatory Surgery Surgical Checklist
- Composite 1. Communication About Patient Information, #2 AORN Comprehensive Surgical Checklist

- Composite 1. Communication About Patient Information, #3 Gastroenterology Safe Surgery Checklist
- Composite 1. Communication About Patient Information, #4 Instructional Videos on Surgical Safety Checklist Use
- Composite 1. Communication About Patient Information, #5 Ophthalmic Surgical Checklist - Ambulatory Surgery Center Association
- Composite 1. Communication About Patient Information, #7 Patient Safety Toolkit: Ambulatory Surgery and Surgical/Procedural Checklists
- Composite 1. Communication About Patient Information, #8 Safe Surgery 2015
- Composite 1. Communication About Patient Information, #10 SBAR Technique for Communication: A Situational Briefing Model

Composite 3. Staffing, Work Pressure, and Pace

1. Staffing of the PACU/Patient Acuity Tool
http://www.ascassociation.org/viewdocument/?DocumentKey=3ab590fe-2c38-4669-87c2-07697dc7caf8

Staffing of the postanethesia care unit is based on using the patient acuity tool, designed by peri-anesthesia nurses at El Camino Surgery Center. This tool allows staffing points to be assigned based on the type of anesthesia and the type of surgery being performed.

2. Predict and Anticipate Patient Needs
http://www.ihi.org/resources/Pages/Changes/PredictandAnticipatePatientNeeds.aspx (requires free account setup and login)

To ensure that patient needs are met and that patients flow smoothly through the clinic process, staff look ahead on the schedule to identify patient needs for a given day or week. This Institute for Healthcare Improvement Web site includes links to more specific information and strategies on predicting and anticipating patient needs.

3. Patient Safety Primer: Missed Nursing Care
https://psnet.ahrq.gov/primers/primer/29

This AHRQ Primer highlights the importance of nurses to safety culture. Missed nursing care is a subset of the category known as error of omission. It refers to needed nursing care that is delayed, partially completed, or not completed at all. Missed nursing care is problematic because nurses coordinate, provide, and evaluate many interventions prescribed by others to treat illness in hospitalized patients. Nurses also plan, deliver, and evaluate nurse-initiated care to manage patients' symptoms and responses to care. Thus, missed nursing care not only constitutes a form of medical error that may affect safety, but also constitutes a unique type of medical underuse. Missed nursing care is linked to patient harm, including falls and infections. Organizations can prevent missed nursing care by ensuring appropriate nurse staffing, promoting a positive safety culture, and making sure needed supplies and equipment are readily available.

Composite 4. Teamwork

1. Five Tips for Creating Effective Teams Quickly
http://www.saferpatients.com/articles/Creating%20Effective%20Teams%20(2).pdf

This tip sheet, developed by LifeWings, offers five proven and practical tips for creating effective teams quickly. High-reliability organizations, such as health care and aviation, often call for skilled professionals to work together with little or no previous knowledge or history of each other. This need to create effective teams quickly is practiced daily/hourly in aircrafts and cockpits around the world. Following these tips will help you build effective teams quickly.

2. Patient Safety Primer: Teamwork Training
https://psnet.ahrq.gov/primers/primer/8

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

3. Patient Safety Primer: Disruptive and Unprofessional Behavior
https://psnet.ahrq.gov/primers/primer/15/disruptive-and-unprofessional-behavior

Disruptive behavior and unprofessional actions increase the potential for medical errors and preventable deaths, as well as leading to staff dissatisfaction and higher turnover. The Agency for Healthcare Research and Quality's Patient Safety Network explains this topic further and provides links for more information on disruptive and unprofessional behavior.

4. Pennsylvania Patient Safety Advisory (Vol.7, Suppl. 2)
http://www.patientsafetyauthority.org/ADVISORIES/AdvisoryLibrary/2010/jun16_7(suppl2)/Documents/jun16;7(suppl2).pdf

This supplement from the Pennsylvania Patient Safety Authority outlines tactics to improve communication, including crew resource management, chain-of-command policies, and teamwork training.

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

Developed jointly by the Department of Defense (DoD) and the Agency for Healthcare Research and Quality, 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. A multimedia TeamSTEPPS® toolkit is available in the public domain.

6. TeamSTEPPS® Office-Based Care Version
http://www.ahrq.gov/professionals/education/curriculum-tools/teamstepps/officebasedcare/index.html

The Office-Based Care version of TeamSTEPPS adapts the core concepts of the TeamSTEPPS program to reflect the environment of office-based care teams. The examples, discussions, and exercises are tailored to the medical office environment. Some ambulatory surgery centers may benefit from elements of this curriculum.

7. Thirteen Things You Must Assess in Your Organization To Create and Sustain a Culture of Safety
http://saferpatients.com/wp-content/uploads/2014/03/13ThingsYouMustAssess-AChecklist-.Updated.pdf

LifeWings offers a free guide for actions health care organizations must take to maintain a culture of patient safety. It covers aspects of teamwork, staff training, and leadership support for safety culture creation and maintenance.

Composite 5. Staff Training

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

The Agency for Healthcare Research and Quality's Patient Safety Education and Training Catalog consists of patient safety programs currently available in the United States. The catalog, which is featured on AHRQ's Patient Safety Network, offers an easily navigable database of patient safety education and training programs consisting of a robust collection of information tagged for easy searching and browsing. The new database identifies a number of characteristics of the programs, including clinical area, program and learning objectives, evaluation measures, and cost. The clinical areas in the database align with the PSNet Collections.

2. Clinical Emergency: Are You Ready in Any Setting?
http://patientsafetyauthority.org/ADVISORIES/AdvisoryLibrary/2010/Jun7%282%29/Pages/52.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. This article discusses the issues associated with the location of clinical emergencies and strategies for facilities to achieve rapid response preparedness.

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

The Centers for Disease Control and Prevention's Hand Hygiene in Healthcare Settings provides health care workers and patients with a variety of resources, including guidelines for providers, patient empowerment materials, the latest technological advances in hand hygiene adherence measurement, frequently asked questions, and links to promotional and educational tools published by the World Health Organization, universities, and health departments.

4. Infection Prevention Training for Ambulatory Surgical Centers
https://cne.memberclicks.net/index.php?option=com_mc&view=mc&mcid=72&eventId=325390&orgId=cne

The Clinical Directors Network, a not-for-profit network of primary care clinicians, researchers, and health care workers, provides several training resources related to preventing healthcare-associated infections in ambulatory care settings. Topics include creating and implementing infection control programs, preventing surgical site infections, and using safe injection practices, as well as cleaning, sterilization, and high-level disinfection.

Cross-references to resources already described:

- Composite 2. Communication Openness, #1 Stop-the-Line Assertive Statements Training
- Composite 4. Teamwork, #7 Thirteen Things You Must Assess in Your Organization To Create and Sustain a Culture of Safety

Composite 6. Organizational Learning – Continuous Improvement

1. Checklist for Change Management
http://www.saferpatients.com/wp-content/uploads/2016/01/Leading-Change-Checklist.pdf

This assessment tool, developed by LifeWings, helps you ensure your project's success by determining if you've taken the actions necessary for effective change management.

2. Decision Tree for Unsafe Acts Culpability
http://www.ihi.org/resources/Pages/Tools/DecisionTreeforUnsafeActsCulpability.aspx (requires free account setup and login)

The decision tree for unsafe acts culpability is a tool available for download from the Institute for Healthcare Improvement Web site. Staff can use this decision tree when analyzing an error or adverse event in an organization to help identify how human factors and systems issues contributed to the event. This decision tree is particularly helpful when working toward a nonpunitive approach in an organization.

3. Department of Veterans Affairs National Center for Patient Safety–Root Cause Analysis
http://www.patientsafety.va.gov/professionals/onthejob/rca.asp

The National Center for Patient Safety uses a multidisciplinary team approach, known as Root Cause Analysis (RCA) to study health care-related adverse events and close calls. The goal of the RCA process is to find out what happened, why it happened, and how to prevent it from happening again. Because the Center's Culture of Safety is based on prevention, not punishment, RCA teams investigate how well patient care systems function. The focus is on the "how" and the "why," not on the "who." Through the application of human factors engineering (HFE) approaches, the National Center for Patient Safety aims to support human performance.

4. Patient Safety Tools for Physician Practices
http://www.hret.org/quality/projects/pppsa.shtml

The Health Research & Educational Trust and its partners at the Institute for Safe Medication Practices and the Medical Group Management Association Center for Research have developed patient safety tools for physician practices. Pathways for Patient Safety™ is a three-part toolkit to help outpatient care settings improve safety in three areas: working as a team, assessing where you stand, and creating medication safety. Another tool, the Physician Practice Patient Assessment, helps physician practices evaluate their processes, clarify opportunities for improvement, measure progress over time, and facilitate dialog among staff.

5. Plan-Do-Study-Act (PDSA) Worksheet
http://www.ihi.org/resources/Pages/Tools/PlanDoStudyActWorksheet.aspx (requires free account setup and login)

The Plan-Do-Study-Act (PDSA) Worksheet from the Institute for Healthcare Improvement 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 needed modifications (Act).

6. Quality Improvement Fundamentals Toolkit
http://www.leadingageny.org/home/assets/File/QI_Fundamentals_toolkit.pdf

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

7. Using Change Concepts for Improvement
http://www.ihi.org/resources/Pages/Changes/UsingChangeConceptsforImprovement.aspx
(requires free account setup and login)

A change concept is a general notion or approach to change that has been found to be useful in developing specific ideas for changes that lead to improvement. This Institute for Healthcare Improvement Web page outlines change concepts such as error proofing, optimizing inventory, and improving workflow.

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

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

Composite 7. Response to Mistakes

1. Call to Action: Safeguarding the Integrity of Healthcare Quality and Safety Systems
http://www.nahq.org/uploads/NAHQ_call_to_action_FINAL.pdf

The National Association for Healthcare Quality *Call to Action: Safeguarding the Integrity of Healthcare Quality and Safety Systems* provides best practices to enhance quality, improve ongoing safety reporting, and protect staff. It addresses accountability, protection of those who report quality and safety concerns, and accurate reporting and response.

2. Leadership Response to a Sentinel Event: Respectful, Effective Crisis Management
http://www.ihi.org/resources/Pages/Tools/LeadershipResponseSentinelEventEffectiveCrisisMgmt.aspx

This page of resources was developed by the Institute for Healthcare Improvement. IHI periodically receives urgent requests from organizations seeking help in the aftermath of a serious organizational event, most often a significant medical error. In responding to such requests, IHI has drawn on learning and examples assembled from many courageous organizations over the last 15 years who have respectfully and effectively managed these crises.

3. Living a Culture of Patient Safety Policy and Brochure
http://www.ihi.org/resources/Pages/Tools/LivingaCultureofPatientSafety.aspx

St. John's Mercy Medical Center created an institutionwide policy regarding nonpunitive reporting. They also created a brochure, *Living a Culture of Patient Safety*, that was developed by St. John's Culture of Safety Subcommittee, signed by the president, and mailed to all worker homes. The brochure reinforces the nonpunitive reporting policy and encourages all workers to report errors.

4. Patient Safety and the "Just Culture"
http://www.health.ny.gov/professionals/patients/patient_safety/conference/2007/docs/patient_safety_and_the_just_culture.pdf

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

5. Saying Sorry
http://www.nhsla.com/Claims/Documents/Saying%20Sorry%20-%20Leaflet.pdf

Although victims of adverse events have clearly expressed their preferences for full error disclosure, most physicians remain uncomfortable with disclosing and apologizing for errors. This leaflet offers information to help clinicians understand the value of effective apologies, along with tips for organizations to support open disclosure efforts.

6. Understand Just Culture
http://www.ahrq.gov/professionals/education/curriculum-tools/cusptoolkit/videos/07a_just_culture/index.html

The Agency for Healthcare Research and Quality offers free resources on developing a "just culture" and applying strategies of the Comprehensive Unit-based Safety Program (CUSP). The Apply CUSP module of the CUSP toolkit presents the principles of a just culture, a nonpunitive environment that encourages reporting of adverse events. Included in the module is this video on understanding just culture.

Cross-references to resources already described:

- Composite 1. Communication About Patient Information, #10 SBAR Technique for Communication: A Situational Briefing Model
- Composite 6. Organizational Learning – Continuous Improvement, #2 Decision Tree for Unsafe Acts Culpability

Composite 8. Management Support for Patient Safety

1. Conduct Patient Safety Leadership WalkRounds™
http://www.ihi.org/resources/Pages/Changes/ConductPatientSafetyLeadershipWalkRounds.aspx (requires free account setup and login)

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 frontline staff. This Institute for Healthcare Improvement Web site discusses the benefits of management making regular rounds and provides links to tools available for download.

2. Safety Huddle Results Collection Tool
http://www.ihi.org/resources/Pages/Tools/SafetyHuddleResultsCollectionTool.aspx (requires free account setup and login)

Safety Briefings increase safety awareness among frontline staff and help an organization develop a culture of safety. To determine whether Safety Briefings are successful in accomplishing these goals, data must be collected to monitor progress. Iowa Health System tested the use of Safety Briefings (which it calls "Safety Huddles") to increase safety awareness and designed a tool to assist its staff with data collection during those tests.

Cross-reference to resource already described:

- Composite 4. Teamwork, #7 Thirteen Things You Must Assess in Your Organization To Create and Sustain a Culture of Safety

Communication in the Surgery/Procedure Room

1. Checklist for Checklist Development

http://www.projectcheck.org/checklist-for-checklists.html

Project Check offers a free downloadable checklist to help health care providers and organizations build a sustainable and effective patient safety checklist. The checklist was developed by Atul Gawande of Brigham and Women's Hospital Center for Surgery and Public Health Dissemination Team and Dan Boorman of Boeing. The checklist ensures that health care providers cover specific bases in the development, drafting, and validation stages.

Cross-references to resources already described:

- Composite 1. Communication About Patient Information, #1 Ambulatory Surgery Surgical Checklist
- Composite 1. Communication About Patient Information, #3 Gastroenterology Safe Surgery Checklist
- Composite 1. Communication About Patient Information, #4 Instructional Videos on Surgical Safety Checklist Use
- Composite 1. Communication About Patient Information, #5 Ophthalmic Surgical Checklist - Ambulatory Surgery Center Association
- Composite 1. Communication About Patient Information, #7 Patient Safety Toolkit: Ambulatory Surgery and Surgical/Procedural Checklists
- Composite 1. Communication About Patient Information, #8 Safe Surgery 2015
- Composite 1. Communication About Patient Information, #10 SBAR Technique for Communication: A Situational Briefing Model

General Resources

1. AHRQ Impact Case Studies

http://www.ahrq.gov/policymakers/case-studies/patient-safety.html

The Agency for Healthcare Research and Quality's patient safety case study portfolio aims to identify risks and hazards that lead to medical errors and find ways to prevent patient injury associated with delivery of health care. This subset of the Agency's Impact Case Studies specific to patient safety highlights these successes, describing the use and impact of AHRQ-funded tools by State and Federal policymakers, health systems, clinicians, academicians, and other professionals.

2. CAHPS® Ambulatory Care Improvement Guide
https://cahps.ahrq.gov/quality-improvement/improvement-guide/improvement-guide.html

The extensive and growing use of CAHPS® (Consumer Assessment of Healthcare Providers and Systems) surveys to assess the quality of health plans, medical groups, and other organizations has created a demand for practical strategies that organizations can use to improve patients' experiences with care. This guide is designed to help meet this need. It is aimed at executives, managers, physicians, and other staff responsible for measuring performance and improving the quality of services provided by health plans, medical groups, and individual physicians. This guide includes new improvement interventions and offers additional resources.

3. Department of Defense Patient Safety Program Toolkits
http://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Quality-And-Safety-of-Healthcare/Patient-Safety/Patient-Safety-Products-And-Services/Toolkits

The Department of Defense Patient Safety Program is a comprehensive program with the goal of establishing a culture of patient safety and quality within the Military Health System. Patient Safety Program Toolkits are available for use as small, self-contained resource modules for training and application. Anyone on the health care team can:

- Use a toolkit as a reference and information source for a specific tool subject.
- Combine a toolkit into existing coursework to introduce team members to the tool's key concepts and its use on clinical units.
- Use a toolkit to create and deliver training on a specific tool.

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

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

5. Infection Control Surveyor Worksheet
http://www.ascassociation.org/viewdocument/?DocumentKey=ae5c22ac-c283-4a36-b548-06ce81f200a0

The Centers for Medicare & Medicaid Services, in conjunction with the Centers for Disease Control and Prevention, have developed a comprehensive infection control worksheet to evaluate compliance with infection control requirements. This worksheet serves as a guide for ambulatory surgery centers that want to fine-tune their infection control practices.

6. **Infection Prevention Checklist for Outpatient Settings: Minimum Expectations for Safe Care**
http://www.ascassociation.org/viewdocument/?DocumentKey=d8c47834-ad16-4683-a193-5190829672cc

Checklist for use in ensuring that the facility has appropriate infection prevention policies and procedures in place and supplies to allow health care personnel to provide safe care. Also used to systematically assess personnel adherence to correct infection prevention practices. (Assessment of adherence should be conducted by direct observation of health care personnel during the performance of their duties.)

7. **Medically Induced Trauma Support Services (MITSS) Tools for Building a Clinician and Staff Support Program**
http://www.mitsstools.org/tool-kit-for-staff-support-for-healthcare-organizations.html

Medically Induced Trauma Support Services (MITSS), a nonprofit organization whose mission is "to support healing and restore hope" to patients, families, and clinicians who have been affected by an adverse medical event, developed a toolkit for clinician support. MITSS also provides an organizational assessment tool and a comprehensive work plan.

8. **Minnesota Alliance for Patient Safety Culture Road Map**
http://mnpatientsafety.org/Culture-Road-Map

The Minnesota Alliance for Patient Safety, a partnership among the Minnesota Hospital Association, Minnesota Medical Association, Minnesota Department of Health, and more than 50 other public and private health care organizations, has developed a safety culture road map for organizations working toward a culture of safety.

9. **Oregon Ambulatory Surgery Center Infection Prevention & Control Toolkit**
http://oregonpatientsafety.org/healthcare-professionals/infection-prevention-toolkit/

The *Oregon Ambulatory Surgery Center Infection Prevention & Control Toolkit* is specifically designed to provide guidance on the development and implementation of infection prevention programs that meet infection control standards outlined in Medicare's Conditions of Coverage and State of Oregon administrative rules. The toolkit was developed by the Oregon Patient Safety Commission to help Oregon's ambulatory surgery centers implement infection prevention quality improvement projects, reduce infection risks, and better protect patients.

10. **Patient Safety Primer: Medication Errors**
https://psnet.ahrq.gov/primers/primer/23

A growing evidence base supports specific strategies to prevent adverse drug events (ADEs). The Agency for Healthcare Research and Quality's Patient Safety Network outlines strategies providers can use at each stage of the medication use pathway–prescribing, transcribing, dispensing, and administering–to prevent ADEs. These strategies range from

computerized provider order entry and clinical decision support to minimizing nurse disruption and providing better patient education and medication labeling. The primer also identifies known risk factors for ADEs, including health literacy, patient characteristics, high- alert medications, and transitions in care.

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

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

12. SAFER Guides
https://www.healthit.gov/safer/

SAFER guides, released by the Office of the National Coordinator for Health Information Technology at the Department of Health and Human Services, are a suite of tools designed to help health care providers and the organizations that support them assess and optimize the safety and safe use of electronic health information technology products, such as electronic health records (EHRs). Each SAFER Guide addresses a critical area associated with the safe use of EHRs through a series of self-assessment checklists, practice worksheets, and recommended practices. Each SAFER Guide has extensive references and is available as a downloadable PDF and as an interactive Web-based tool.

Areas addressed include the following:

- High Priority Practices
- Organizational Responsibilities
- Patient Identification
- Computerized Physician Order Entry With Decision Support
- Test Results Review and Followup
- Clinician Communication
- Contingency Planning
- System Interfaces
- System Configuration